HEALTH CARE FINANCING REVIEW

Celebrating 35 Years of Medicare and Medicaid: Perspectives on the Past, Present, and Future

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INTRODUCTION

> *Medical care will free millions from their miseries. It will signal a deep and lasting change in the American way of life. It will take its place beside Social Security and together they will form the twin pillars of protection upon which all our people can safely build their lives and their hopes.* President Lyndon Baines Johnson in June 1966 speaking to the National Council of Senior Citizens shortly before implementation of the Medicare program.

The 1965 enactment of the Medicare and Medicaid programs is among the most important domestic legislative achievements of the post-World War II era. Medicare provided health insurance to Americans age 65 or over and, eventually, to people with disabilities. For its part, Medicaid provided Federal matching funds so States could provide additional health insurance to many low-income elderly and people with disabilities. Moreover, Medicaid established the principle that a comprehensive, Federal program would assume some measure of responsibility to provide for the health care needs of low-income parents and their dependent children. On July 30, 1965, when he signed the bill into law at the Truman Library in Independence, Missouri, President Johnson said:

"No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying our their deep moral obligations to their parents, and to their uncles, and to their aunts. . . No longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

The legislation was the political brainchild of House Ways and Means Committee Chairman Wilbur Mills; it was called a "three layer cake." The first layer was the Johnson Administration's proposed "Medicare" program; a mandatory plan to cover the elderly's hospital (but not physician) costs which Mills called Medicare Part A. For the second layer, Mills took the voluntary plan favored by the American Medical Association and Republicans (both opposed Johnson's mandatory program) and turned it into voluntary coverage for the elderly's physician costs which Mills called Medicare Part B. For the third layer, Medicaid, Mills expanded existing Federal funds provided to States to care for poor elderly, disabled, and parents and their dependent children.

In the 35 years since President Johnson spoke, Medicare has cumulatively provided more than 93 million elderly and disabled Americans with affordable health care coverage and access to high-quality medical care. During the same period, Medicaid has provided millions of low-income families, elderly and disabled Americans with health care services. Today, Medicare serves 39 million beneficiaries, or 14 percent of the population, and in 30 years the number of Americans covered will nearly double to 77 million or 22 percent of the population. In

1998, Medicaid covered more than 41 million Americans, or more than 12 percent of the population. For more information on multiple ways totally Medicaid enrollment refer to Provost (2000).

Together, Medicare and Medicaid serve nearly one in four Americans and finance about $1 in every $3 that the Nation spends on health care. The programs also spend a significant share of the Federal Government's budget: about $1 in every $5. By any measure, share of the population served, share of the Nation's health dollar, or share of the Federal Government's budget, over the last 35 years, the programs have become an important part of the Nation's health care system and social fabric.

But data and analysis explain only part of the reason we celebrate these essential programs. In this 35th anniversary year of Medicare and Medicaid, I would like to highlight the voices of some of those Medicare and Medicaid beneficiaries whom we serve. I have a deep appreciation for the role of analysis in running our public programs, and the authors in this volume of the *Health Care Financing Review* make a vital contribution to our understanding of program policy and administration. But during my tenure as Administrator, I am especially fortunate to have had the opportunity to gauge the impact of Medicare and Medicaid in a less scientific manner as well—by listening to our beneficiaries. In the following sections, as we review 35 years of accomplishments and prospects for the future, a few of these beneficiaries will speak for themselves.

MEDICARE'S ACCOMPLISHMENTS

> *I think they should keep Medicare. Medicare is very, very good. It is better than it used to be when people were suffering and couldn't pay a doctor bill.* Medicare Beneficiary, 1999 Medicare Current Beneficiary Survey

Medicare has made a dramatic difference in the number of seniors who are insured against health care costs and has improved access to services. Life expectancy has increased by 3 years at age 65, or 20 percent, since 1960. More important than simply adding more years to a senior citizen's life, Medicare has helped to improve the quality of those years. For example, cataract surgery means that vision can be restored, artificial knees and hips means that mobility can be retained, cardiac bypass, and organ transplant surgery means that life itself can be extended. In fact, research has found that the prevalence of disabilities in the elderly as they age are lower than previous data would have suggested, providing additional evidence that the quality of life is improving for the Nation's elders. Medicare coverage has helped keep millions of seniors and their families out of poverty as a result of illness or disability. And by requiring hospitals accepting Medicare funding to be integrated for all patients, Medicare played a powerful, but often overlooked, role in expanding access to high-quality care for minority seniors and for all Americans who are members of minority groups.

Medicare has also made a major contribution to the American health care system by providing a stable source of payment for a large segment of the population that has substantial health care needs. Medicare's payment systems have been a model for other insurance carriers in the U.S. as well as around the world. Medicare's payment systems have also helped to change the health services delivery system. For example, after Medicare's prospective payment

system for hospital services was implemented, hospital cost growth slowed, the average length of a hospital stay declined and ambulatory care alternatives like home health services grew for both public and private payers. Medicare has established strong Federal standards for the quality of hospitals, nursing homes, and home health care agencies that benefit all Americans. And Medicare has some of the strongest patient protections for beneficiaries enrolled in health maintenance organizations and other managed care plans.

MEDICAID'S ACCOMPLISHMENTS

> *Medicaid, in particular, forms the bedrock of our Nation's response to caring for people living with HIV*. Donald Minor, living with HIV and hemophilia, in testimony before the Senate Aging committee.

> *One of our medicines is $18….and we had to pay $5 for it. And it's helped us. I tell you it helped us. It's the only thing that's keeping us going*. Medicaid Beneficiary in Sacramento, California

Medicaid is in many ways a constellation of programs serving many different vulnerable population groups with varied health care needs. For many elderly Americans, it covers the high cost of nursing home care after their savings and income have been exhausted. Nearly one-half of the Nation's nursing home bill is covered by Medicaid. For elderly Americans just above the poverty line, Medicaid covers Medicare's cost sharing and Part B premium obligations. For new mothers, Medicaid covers the cost of childbirth. About one in three of the Nation's births is covered by Medicaid. For many disabled citizens, Medicaid covers the costs of medical equipment, personal attendant services, and other services allowing them to live independently in the community. For children, Medicaid covers immunizations and other preventive and screening services in order to catch and treat problems at the earliest possible age. When children are newly insured, they are not hospitalized as often for conditions that can be treated in ambulatory settings; this is especially helpful for asthmatic children who need good primary care. For many children with special health care needs, Medicaid covers the specialized care they need to have a chance of growing up at home, outside the confines of an institution. And for many Americans with HIV, it covers the costs of life-sustaining treatments. Medicaid covers 90 percent of children with HIV and about one-half of adults with AIDs.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

> *What do I worry about as a parent? I know one of my biggest worries is my daughter's well-being. If she is healthy the rest we can deal with. Last year for several months, we were without health insurance— and I really felt we were living on borrowed time. I was constantly worried— what if my daughter breaks her arm, or was in a car accident, or just got really sick—how would I pay for that with no health insurance? It's a frightening position to be in*. Kentucky Parent

Before Medicare was enacted, the elderly were among the population groups most likely to be without health insurance. Now, children are among the population groups most likely to be without health insurance: more than 11 million children, or one in seven, are uninsured. To address this problem, the SCHIP was enacted in 1997 to provide health insurance coverage to children from working families who do not qualify for Medicaid and cannot afford private insurance.

CHALLENGES FOR THE FUTURE

I just hope it [Medicare] *lasts, because I could not manage without it.* Medicare Beneficiary, 1999 Medicare Current Beneficiary Survey

On a bipartisan basis, Medicare reforms over the last several years have included: enactment of the Balanced Budget Act of 1997 (which brought many important changes to the program including new preventive benefits for beneficiaries); reducing waste, fraud, and abuse in the program; and extending solvency of the Medicare Hospital Insurance Trust Fund until 2025. These changes form a strong basis for optimism that we will be able to meet the challenges of Medicare's future responsibly, while focusing first and foremost on what beneficiaries need.

While the Medicare and Medicaid programs have been very important to the millions of Americans served by them, there are challenges to the ability of the programs to continue that service. For Medicare, the challenges include updating the benefit package to reflect what is now the norm for the private sector, notably coverage for outpatient prescription drugs. For Medicaid and SCHIP reaching out to and enrolling all of the Americans eligible for coverage remains a challenge. The impact of welfare reform on Medicaid enrollment means we have more work ahead to make sure that program benefits are available to everyone who is eligible. For both Medicare and Medicaid, as the Nation's baby-boom generation ages over the next several decades, Utilization of health services increase rapidly, challenging the Nation's ability to continue to provide high quality services to the elderly.

OVERVIEW OF THE 35TH ANNIVERSARY EDITION

Thanks to you my son has glasses for the first time. Kansas Parent

I commissioned this issue of the *Health Care Financing Review* to bring together the best thinking from independent policy experts and HCFA staff as we celebrate the 35th anniversary of Medicare and Medicaid. I have asked two public policy experts to draw upon their knowledge of the programs, and write about the important challenges we face in the future, while reflecting upon the achievements of the last 35 years.

Marilyn Moon brings her experience as a public trustee of the Medicare Trust Funds and as a scholar of Medicare at the Urban Institute to bear in her article, "Medicare Matters: Building on a Record of Accomplishments," she discusses reform proposals in light of the program's original goals: access to mainstream care, a commitment to pooling risks, and additional help to those in need. She argues that Medicare has met those original goals. She cautions that the challenge of simultaneously improving the benefit package and financing care for the baby-boom generation will likely require new revenues and should be done with the program's original goals in mind.

Diane Rowland, the Executive Director of the Henry J. Kaiser Family Foundation's Commission on Medicaid and the Uninsured, brings her experience as one of the Nation's foremost public policy analysts on Medicaid to bear in her article "Health Care for the Poor: Medicaid at 35," she discusses Medicaid's achievements: improving access to health care and improving

health status while moderating growth in the ranks of the uninsured. She discusses the back and forth between States and the Federal Government over their respective roles. She argues that Medicaid is critical to assuring access to health services for a broad array of groups: families with children, pregnant women, the disabled and the elderly. She argues that the future effectiveness of the program in providing coverage will depend upon whether it can be transformed into a health insurance program that includes all low-income people regardless of their family status.

To complement their work, I asked several HCFA staff to reflect upon a number of additional important topics in short vignettes.

Medicare

Rick Foster, our Chief Actuary, reviews the general financial history of the hospital insurance (HI) and supplementory medical insurance (SMI) trust funds and projections for the future in his article "Trends in Medicare Expenditures and Financial Status, 1966-2000." The history of Medicare's spending growth is a pattern of "relatively rapid growth in most years, with occasional periods of slower growth attributable to important legislative or administrative initiatives." He urges timely action to address the financial impact of the impending enrollment of the baby-boom generation. He closes by noting that "public confidence in government and government programs is enhanced by their efficient operation and freedom from crises—especially those foreseeable many years in advance."

Robert Myers, a former Chief Actuary of the Social Security Administration, in his article "Why Medicare Part A and Part B, as Well as Medicaid?" graciously provides us with an historical note on the political compromises that resulted in the surprising enactment of Medicare and Medicaid.

Paul Eggers, National Institute of Diabetes and Digestive and Kidney Diseases at the National Institutes of Health writes in his article, "Medicare's End Stage Renal Disease Program" about the life-saving ESRD program in Medicare, where prior to Medicare's coverage, hospitals were forced to make life and death decisions for patients needing expensive dialysis services. Since 1973, Medicare has financed the "gift of life" for more than 1 million beneficiaries with ESRD.

Carlos Zarabozo, Office of Strategic Planning, in his article, "Milestones in Medicare Managed Care" reviews the history of managed care in Medicare, from the earliest days of the program through today, when Medicare+Choice is faced with the turmoil in the larger managed care marketplace.

Anita Bhatia, Sheila Blackstock, Rachel Nelson and Terry Ng, from the Office of Clinical Standards and Quality, discuss in their article, "Evolution of Quality Review programs for Medicare: Quality Assurance to Quality Improvement" the evolution of quality in the Medicare program from a retrospective quality review strategy to a proactive, quality improvement approach.

Nancy De Lew, Office of Strategic Planning, in her article, "Medicare: 35 Years of Service" rounds out the Medicare section by highlighting key data regarding beneficiary characteristics, program spending, and Medicare's role in the broader health system.

Medicaid

John Klemm, Office of the Actuary, in his article, "Medicaid Spending: A Brief History" reviews the history of Medicaid spending and enrollment over the last 35 years. He finds that the "factors that have driven Medicaid

spending over the years have varied greatly from one era to the next, resulting in extreme variation in spending growth over time."

Jan Shankroff, Patricia Miller, Marvin Feuerberg, and Edward Mortimore, Center on Medicaid and State Operations, in their article, "Nursing Home Initiative" review the challenges facing the Nation's nursing homes in improving quality of care for the more than 1.5 million residents of these facilities. Nursing home reform legislation enacted in 1987 sought to improve quality and the review shows that more remains to be done to fulfill the goals of the legislation.

T. Randolph Graydon, Center for Medicaid and State Operations, in his article, "Medicaid and the HIV/AIDS Epidemic in the United States" writes about the critical role that Medicaid plays, as the Nation's largest payer, in financing the health care of 90 percent of children living with AIDS and one-half of all those living with AIDS.

Mary Jean Duckett and Mary Guy, Center for Medicaid and State Operations, in their article, "Home and Community-Based Services Waivers" write about home and community-based waivers which allow States to use Medicaid funds for people, who would otherwise qualify for nursing home care, to be cared for at home or in other community residential settings.

Clarke Cagey, Center for Medicaid and State Operations, in his article, "Health Reform, Year Seven: Observations About Medicaid Managed Care" provides an assessment of State health care reform efforts over the last 7 years. He finds that large coverage expansions have been replaced, now that the SCHIP is in place, by new State strategies to target managed care enrollment on high cost populations.

Rosemarie Hakim and Paul Boben, Office of Strategic Planning and Jennifer Bonney, Center for Medicaid and State Operations, in their article, "Medicaid and the Health of Children" find that Medicaid coverage has contributed to significant improvements in the health of low-income children citing decreases in the number of childhood deaths, hospitalizations, and emergency room visits and increased immunizations and other preventive services in the wake of Medicaid coverage. However, they argue that there is still room for improvement given that "access to care is still less than that enjoyed by privately insured children."

Christy Provost and Paul Hughes, Office of Strategic Planning, in their article, "Medicaid: 35 Years of Service" round out the Medicaid section by highlighting key data regarding beneficiary characteristics, program spending, and Medicaid's role in the broader health system.

Program Overview

We close the issue with an article by Earl Dirk Hoffman, Barbara Klees, and Catherine Curtis, Office of the Actuary, entitled, "Overview of the Medicare and Medicaid Program," which reviews historical data about the programs as well as their current structure.

CONCLUSION

> *My son has asthma. Before we had the CHIPS card I could not afford proper care for him. This program is a real blessing for us. Now my son is getting the medical care he needs. Thank You!* West Virginia parent

As we celebrate the 35th anniversary of Medicare and Medicaid, this edition of the *Health Care Financing Review* examines the role these programs have played in improving the health and well being of America's senior citizens, people with dis-

abilities, and families with children. It examines the impact these programs have had on the American health care system and their evolution to improve benefits, eligibility, and financing. Finally, the volume looks at the challenges these programs face in meeting the needs of future beneficiaries. It is my hope that, as we debate the future of social insurance programs in America, we will pause to reflect upon the 35 years of health security Medicare and Medicaid have provided to our families and our fellow citizens. With that in mind, I would like to close my introduction as it began, with the voices of beneficiaries:

If it wasn't for Medicare, what would we do? Medicare Beneficiary, 1999 Medicare Current Beneficiary Survey

Since getting this CHIP coverage for my boys, I have had a lot less worry and stress. We were at the point of choosing between groceries and health coverage for the boys….We would not have been able to get them the medicine or doctor visit without CHIP. West Virginia parent of a child enrolled in SCHIP.

A lady comes to help me bathe and shave…I was eating one meal a day and it's just not enough. I went down to 108 pounds. I probably would have died there. A 74 year old male Medicaid beneficiary who lived alone in Kansas prior to receiving home health and other Medicaid covered services.

REFERENCE

Provost, C. and Hughes, P.: Medicaid: 35 Years of Service, *Health Care Financing Review* 21(5):xxx-xxx, Fall 2000.

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Medicare Matters: Building on a Record of Accomplishments

Marilyn Moon, Ph.D.

Medicare's successes over the past 35 years include doubling the number of persons age 65 or over with health insurance, increasing access to mainstream health care services, and substantially reducing the financial burdens faced by older Americans. Medicare reform remains high on the list of priorities of many policymakers because of rapid past and expected future growth in Medicare. If the original goals of the program—including providing mainstream care, pooling of risks, and offering help to those most in need—are to be protected, however, a go-slow approach for greater reliance on the private sector is in order.

INTRODUCTION

Thirty-five years ago, the Medicare program was passed as part of the Great Society legislation of the Lyndon Johnson years, although it had its antecedents in earlier national health insurance proposals. Since 1966, when the program first enrolled beneficiaries, it has succeeded in covering almost all persons age 65 or over, and later, a substantial number of persons with disabilities. Moreover, Medicare provides its beneficiaries with access to most doctors, hospitals, and other providers of health care services. It remains one of the most popular public programs and gets higher marks from its beneficiaries than do most private health insurance companies serving the younger population. In 2000, Medicare served 39 million beneficiaries–more than a doubling of the number covered in 1966.

At the same time, since the 1980s, there have been recurring efforts to slow the growth in Medicare spending, and since the 1990s, there has been a call for even more dramatic measures to "save" Medicare. Spending on the program of $213 billion in 1999 represents a large commitment of resources. But calls for major reform also have critics who maintain that such changes could undermine the program's basic strengths. The stakes in this debate will intensify as the number of persons eligible for Medicare swells with the aging of the baby-boom generation.

Before examining issues facing Medicare, it is important to put the debate in context with a look both at past performance and at some of the original goals of the Medicare program. Will Medicare's future keep faith with its past?

MEDICARE'S ACCOMPLISHMENTS

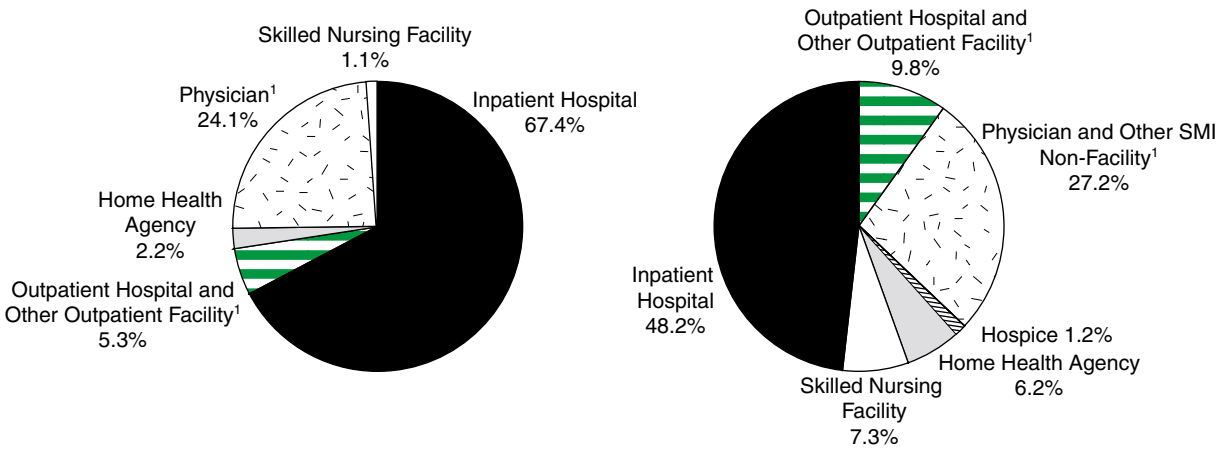
When Medicare began in 1966, it almost immediately doubled the share of persons age 65 or over covered by insurance. Before Medicare, only about one-half of persons in this age group had insurance (Andersen, Lion, and Anderson, 1976). By 1970, 97 percent of older Americans were enrolled, and that proportion has remained about the same ever since (Moon, 1996a).

Two effects followed immediately: Use of services by the population grew, and financial burdens on older Americans and their families declined. Thus, access increased, particularly for those who previously

The author is with The Urban Institute. The views expressed in this article are those of the author and do not necessarily reflect the views of The Urban Institute or the Health Care Financing Administration (HCFA).

Figure 1

Where the Medicare Dollar Went: 1980 and 1998



[1] The definition of these categories has changed over time, so they are not directly comparable over the period.

NOTES: SMI is Supplemental Medical Insurance. Managed care spending is incorporated within the categories.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

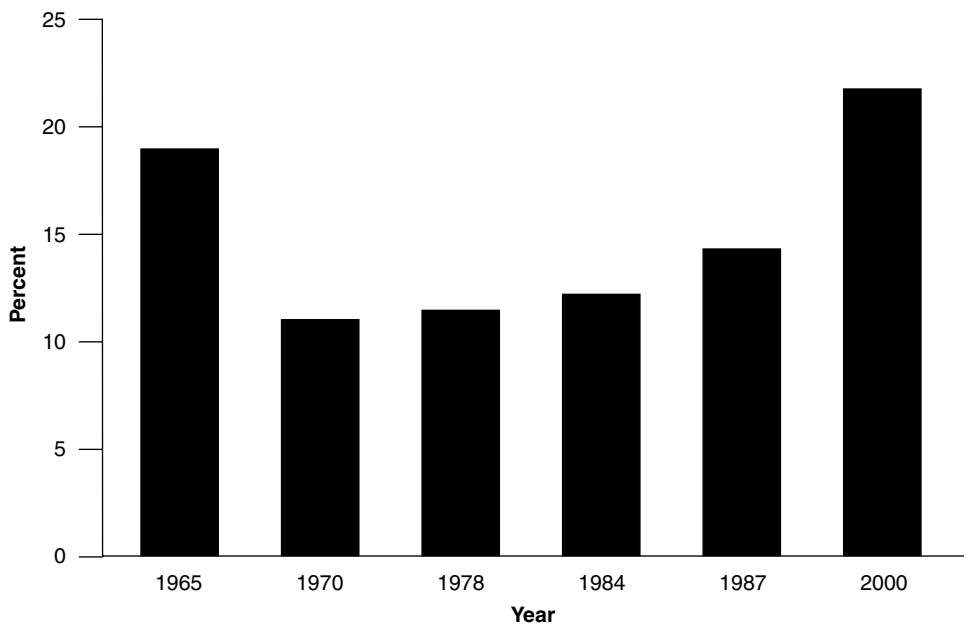
lacked the resources to obtain services. Although Medicare's benefit package has changed little since 1965, in those areas where services are covered, the program has kept up with the times (Figure 1). Many surgeries are now performed on an outpatient basis, for example. Today, even the oldest old have access to mainstream medical care. New technology is available to beneficiaries, and in some cases, the dissemination of new procedures occurs at a faster pace for the old than for the young (Moon, 1999). Perhaps even more important, Medicare played a crucial role in speeding the desegregation of hospitals and other medical facilities, ensuring not only that minority seniors would receive care but that minority persons of all ages would have access to health care services. It is easy to forget that in 1965, for example, many black people could not go to the best hospitals, particularly in the South (Height, 1996; Stevens, 1996).

Financial burdens for seniors also fell nearly in half as a result of Medicare's introduction. Over time, the share of income that seniors spend on health care has crept back up, but the burdens would be much greater if Medicare were not there. In 1965, the typical elderly person spent about 19 percent of his or her income on health care. That share fell to about 11 percent in 1968. Today it is more than 20 percent (Figure 2). Medicare's contribution to the costs of health care for seniors totals more than $5,300, nearly 40 percent of the median income of persons age 65 or over. So, without Medicare, most of those now covered would pay more for their care, and many people would likely have to cut back on the amount of care they receive.

Even in the area of the costs of care, Medicare can point to substantial accomplishments. It was a leader in cost-containment activities in the 1980s, improving upon payment to hospitals and doctors by shifting

Figure 2

Acute Health Care Spending by Elderly as a Share of Income: Selected Years, 1965-2000



SOURCES: Health Care Financing Administration, Office of the Actuary; U.S. Bureau of Labor Statistics: *Current Population Survey.* Washington, DC.1965-2000; Moon, M., Urban Institute, Washington, DC, 2000.

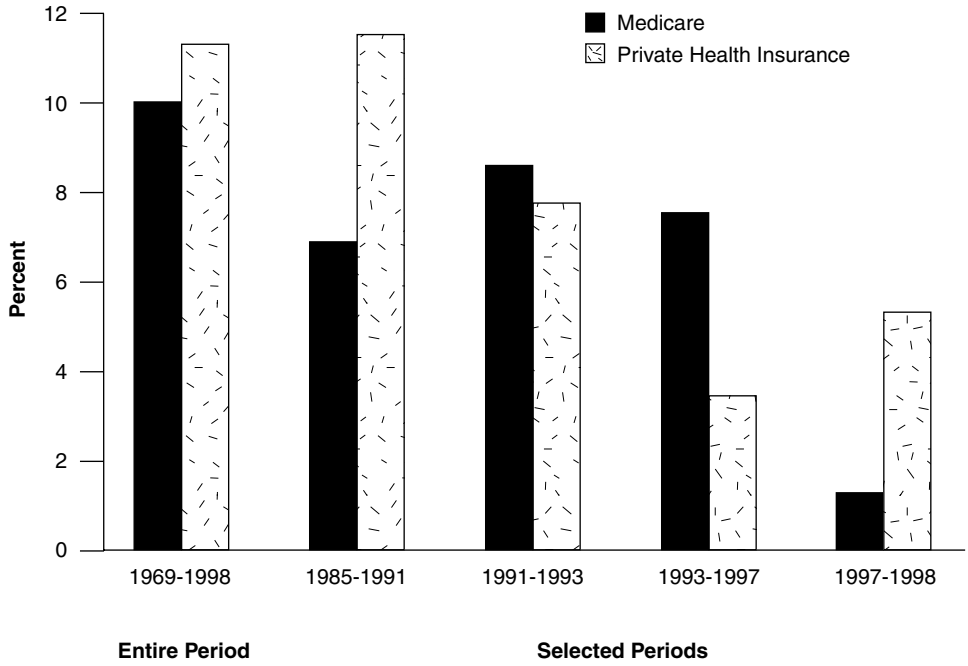
from a cost-based system to one in which payments are known and, in the case of hospitals, do not encourage excess use of services. Both of these systems have since been adopted by a number of other insurers. Further, these and other changes helped moderate the growth of Medicare spending such that, on a per capita basis, Medicare payments have grown more slowly than private insurance costs in most years (Figure 3). Moreover, on a cumulative basis, Medicare has performed better than private insurance from 1970 to 1997 despite increased efforts by employers to move those they cover to managed care in the 1990s (Moon, 1999).

Medicare has also changed over time to allow beneficiaries to choose to be served by private plans instead of remaining in the traditional fee-for-service part of the program. In 1997, this option was modified to allow plans other than health maintenance organizations (HMOs) to participate and to reform the payment system that, on average, costs Medicare more for each enrollee than if they remained in the traditional program (Riley, Ingber, and Tudor, 1997). This new Medicare+Choice benefit has been one of the least successful changes in Medicare. The limits imposed on payments by 1997 legislation have been strongly criticized by the private sector, creating an impasse in the program that will be difficult to overcome. Plans will likely continue to withdraw from participation, and there will be efforts to increase payments to plans, even if this means a less efficient Medicare program.

Finally, improvements in life expectancy since 1965 have occurred at a faster pace for persons age 65 or over than for the population as a whole. In 1960, females faced a life expectancy at age 65 of 15.8 years; by 1998, that figure was up to 19.2 years. For males, the increase in life expectancy over the same period was from 12.8 to 16.0 years (National

Figure 3

Average Growth in per Enrollee Medicare and Private Health Insurance Spending: Selected Periods, 1969-1998



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the National Health Statistics Group, 2000.

Center for Health Statistics, 2000). Some of this improvement is undoubtedly a byproduct of Medicare and Medicaid.

BASIC ISSUES FACING FUTURE REFORMS

Sometimes lost in the enthusiasm to reform Medicare is a careful assessment of whether the original principles and goals for the program can and should be retained. Each of these goals raises questions that need to be revisited in any debate about Medicare's future.

Mainstream Care

During the debate over Medicare's passage, a clear goal was to assure that beneficiaries had access to mainstream care. With criticism and concern expressed by the providers of care, there was reason to worry that Medicare would be considered a second-class program. Efforts to address this concern occurred on several levels: making the program operate like other good private insurance policies of the time and structuring Medicare so as to encourage most providers of health care to participate in it. The legislation thus contained assurances about levels of payment and non-interference in the practice of medicine (Myers, 1970).

Today, this goal is often raised in two areas of reform discussions. First is the issue of the adequacy of the benefit package. Over the last 35 years, much has changed in what is covered in private sector plans, making Medicare's coverage inadequate in comparison. Lack of prescription drug coverage and no limits on cost sharing are two of the most important of these differences.

Second, given that much of the private sector has shifted to managed care, would similar changes to Medicare be appropriate as well? The original goal of assuring "mainstream care" was to provide access to high-quality care. Given the dissatisfaction of many with managed care and the current flux in the delivery system, does putting Medicare beneficiaries in managed care mean keeping up with the times or subjecting beneficiaries to the problem-plagued system the rest of us face? Does managed care in its present form represent an improvement in the delivery of care? This key issue in the debate relates to how much effort should be placed on using private plans to serve the Medicare population.

Commitment to Pooling Risks

One of Medicare's accomplishments is that the very old and the very sick have access to the same basic benefits as younger, healthier beneficiaries. Although there is certainly room for improvement, Medicare is insurance that is never rescinded because of the poor health of the individual. In fact, by expanding coverage to persons with disabilities in 1972, Medicare redoubled its commitment to insuring those who are most in need. Further, the premium for Part B, which is the contribution that most enrollees make while enrolled in Medicare, is the same for all beneficiaries regardless of age or health status.

In the private sector, even when there is a commitment to sharing risks, risk-pooling at the same level available through traditional Medicare is difficult to achieve. When individuals can move from plan to plan, insurers face a strong incentive to seek those who are just a little healthier on average. In that way, plans can offer better services to their clients for a given price. This is good for some enrollees, but the breakup in the risk pool can be extremely detrimental to persons with the greatest needs.

Consequently, this goal is likely to come into conflict with options to rely upon private insurance plans to serve the Medicare population and to allow such plans to tailor their benefits so as to attract particular groups. By the very nature of such "choices," the risk pool is split, and as yet, efforts to adjust for risk differences have fallen short. Do the advantages of private options outweigh the benefits of risk-pooling?

Additional Help to Those in Need

By making Medicare a benefit available to all who qualify and setting contributions on the basis of ability to pay, Medicare also meets the principle of "social" insurance. When Medicare began, persons without insurance—and hence the most likely to gain from its introduction—tended to have lower incomes and to be the oldest among those age 65 or over. One of the reasons for a public commitment to health care for the elderly and disabled is to achieve some equality in services regardless of ability to pay.

This goal is currently at issue concerning expansion of benefits: Should improvements be universal or limited to those with the fewest resources? Medicare was introduced as a universal program, even though some would benefit more than others, as a way to achieve and retain broad support. Thus, even in the beginning of the program, the universal nature of the legislation created some who benefitted more than others. Are the benefits of this proven approach sufficient to justify the higher costs of a universal benefit, compared with a more targeted one?

CHALLENGES FACING MEDICARE

A broad range of issues will be faced by the Medicare program as the baby boom ages and as the overall health care delivery system evolves over time. The two major challenges facing Medicare are to some extent contradictory: the need to deal with the inadequacy of the benefit package and the desire to prevent the program from consuming too large a share of our Nation's resources. This latter concern has diminished in urgency as the outlook for Medicare's future has improved since 1997. Projections from the 2000 trustees' reports (Board of Trustees of the Federal Hospital Insurance Trust Fund, 2000; Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, 2000) indicate that Medicare's share of the gross domestic product (GDP) from both parts of the program will reach 3.95 percent in 2025, up from 2.29 percent in 1999. This still represents a substantial increase in the projected GDP devoted to care—a 72.5-percent rise—but the number of persons projected to be served will have increased over the same period by 78.5 percent. At that time, Medicare will serve about one in every five Americans. Thus, a legitimate concern is to what extent it is desirable to drive spending lower, and if so, by how much? Improving the adequacy of benefits will also require an additional commitment of resources. It is unlikely that reforms to the Medicare program will be sufficient to eliminate all need for further tax contributions over time; indeed as a society, we may well decide to devote substantial additional resources to Medicare.

Improved Benefits

It is hard to imagine a "reformed" Medicare program that does not address two key areas of coverage: prescription drugs and a limit on the out-of-pocket costs that any individual beneficiary must pay. When Medicare was passed in 1965, the benefit package was reasonable, compared with other available private insurance. But over time, private insurance has expanded upon what is covered, while Medicare has changed little.

Critics of Medicare rightly point out that the inadequacy of the benefit package has led to the development of a variety of supplemental insurance arrangements, which in turn creates an inefficient system with most beneficiaries relying on two sources of insurance to meet their needs. Medicaid and employer-sponsored retiree benefits do a pretty good job of comprehensively filling in the gaps. But private supplemental (medigap) plans—which serve about one-quarter of all beneficiaries—are becoming unaffordable for those with average incomes. Costs of policies have risen rapidly as the risk pool becomes more heavily weighted with less healthy beneficiaries (Alexcih et al., 1997). Moreover, plans have moved away from community-rated premiums to arrangements where premiums rise dramatically with age. Consequently, these experience-rated medigap plans shift costs onto those beneficiaries least able to pay.

Without a comprehensive benefit package that includes those elements of care that naturally attract sicker patients, viable competition without risk selection among private plans (either in the current Medicare+Choice or its successor) will be difficult to attain. For example, the problems with the current Medicare+Choice system relate more to affording the rising costs of the additional benefits they add to the basic package than to the costs of Medicare-covered benefits. In particular, private managed care plans that have been offering prescription drug benefits find that they attract sicker patients, and

consequently they have been cutting back on these benefits (Gold et al., 1999). If all plans had to offer a basic prescription drug benefit, for example, and payments from Medicare to these plans increased to reflect that new benefit, competition might actually improve. Certainly this would be a fairer approach than simply giving Medicare+Choice plans more money to retain such benefits while not providing them for persons in traditional Medicare.

Thus, a concerted effort to expand benefits is necessary if Medicare is to be an efficient and effective program. The most straightforward approach would be to revise the Medicare package. Alternatively, to make such an expansion work as a voluntary add-on, a subsidy sufficient to entice even healthy beneficiaries to sign up for extra benefits would be needed.

Prescription Drugs

Prescription drug coverage is a logical expansion of Medicare. Drugs are now, more than ever, a critical part of a comprehensive health care delivery system. Lack of compliance with prescribed medications can lead to higher costs of health care over time. And for many who need multiple prescriptions, the costs can be beyond their reach. The private sector, both through medigap and Medicare+Choice, is failing to fill in the gaps and making coverage less available each year. Thus, to assure future availability, prescription drugs are a crucial—but expensive—piece of an expanded benefit package.

Cost-Sharing Changes

Expansion of coverage to drugs alone is unlikely to be enough to entice enrollees in traditional Medicare to forego supplemental plans, because cost sharing under the current program rules can be very high. In particular, the lack of an upper-bound limit on what people can owe causes problems. Adopting a more rational Medicare cost-sharing package would not have to be extraordinarily expensive if it increased cost sharing in areas that are low now, compared with private plans, while reducing the unusually high hospital deductible and adding stop-loss protection (Moon, 1996b; Gluck and Moon, 2000). Medicare's cost sharing could be brought more in line with what the rest of the population faces without resorting to full first dollar coverage. The difficulty with this approach is that liabilities for cost sharing would rise for many beneficiaries, while the protections would apply to a more limited group (although the amount protected would be substantial), creating more "losers" than "winners." Many of those who would pay more to Medicare could still come out ahead of the current system, however, by not paying the $1,000 or more per year they now spend on medigap. And as medigap becomes more expensive, this type of change will become more attractive over time.

Other Benefit Issues

A number of special problems face the disabled Medicare population under age 65. The 24-month waiting period before a Social Security disability recipient becomes eligible for coverage creates severe hardships for some beneficiaries who must pay enormous costs out of pocket or delay treatments that could improve their disabilities. In addition, a disproportionate share of the disability population has mental health needs, and Medicare's benefits in this area are seriously lacking.

Finally, the need to provide protections for low-income beneficiaries has still not been well met by the current system. Income cutoff levels for eligibility for special

benefits offered through Medicaid are restrictive, excluding many modest-income beneficiaries. Participation in the qualified Medicare beneficiary and related programs is low, in part, because they are housed in the Medicaid program and thus tainted by its association with a "welfare" program. Further, States, which pay part of the costs, tend to be unenthusiastic about these programs and likely also discourage participation. Beneficiaries alike in all ways except State of residence may face very different levels of protection.

Greater Efficiency in Care Delivery

Health care spending under Medicare has risen over time as a result of growth both in the numbers of persons served by the program and in the per capita costs of providing care. But most of the attention on ways to slow Medicare's growth has focused on expenditures. Although there is general agreement that changes to enhance Medicare's efficiency and effectiveness are reasonable concerns, the more difficult question is how this should be done. Can we expect the private market to do better in the future at controlling health care costs than Medicare? Two claims are generally made for why the private sector might be more effective. First is that by encouraging plans to compete with each other, they might find innovative ways to limit their costs. And second, private plans are simply more likely to be efficient. Much of the debate on Medicare's future centers on assessing these claims.

To make price competition among private plans work, proposals call for beneficiaries to bear higher premiums if they choose more expensive plans—an approach often referred to as "premium support." The theory is that beneficiaries will become more price conscious and choose lower cost plans if they have economic incentives to do so. This in turn will reward private insurers that hold down costs. Evidence from the Federal employees' health care system and the California public employees' system indicates that this approach can discipline the insurance market to some degree (U.S. General Accounting Office, 1993; Merlis, 1999). Studies that have focused on retirees, however, show much less sensitivity to price differences (Buchmueller, 2000). Older persons may be less willing to change doctors and learn new insurance rules in order to save a few dollars each month. Thus, it is not known if such a system will work for Medicare.

In addition, premium support may generate a set of problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care (Weiss and Blustein, 1996). And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable may end up being concentrated in plans that become increasingly expensive over time. Further, private plans by design are interested in satisfying their own customers and generating profits for stockholders. They cannot be expected to meet larger social goals such as making sure that the sickest beneficiaries get high-quality care. If such goals remain important, additional protections will have to be added to a premium support approach to balance these concerns.

Competition among private plans does not magically lead to lower costs. It is what plans do to reduce costs that matters. So how does Medicare compare with the private sector? Health care cost increases arise from three main sources: the price charged for services, the basic efficiency of the delivery system, and the number of services delivered.

Medicare has always been competitive in terms of holding down the price it is willing to pay for services, particularly in the key areas of hospital and physician payment. Studies have consistently indicated that Medicare historically has paid hospitals below their costs (Prospective Payment Assessment Commission, 1997), and the fees that Medicare pays for physician services tend to be below even what insurers who demand discounts pay (Zuckerman and Verrilli, 1995). In other areas, such as home health care and skilled nursing facilities, Medicare needs to do better and is in the process of developing and instituting prospective payment systems. At the least, private plans do not have an advantage in terms of pricing services.

When examining the efficiency of alternative approaches, Medicare scores very well in terms of administrative costs, averaging less than 3 percent of the cost of providing care (Board of Trustees of the Federal Hospital Insurance Trust Fund, 2000; Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, 2000). This track record is substantially better than the private sector. Administrative costs are not the only issue, however; in fact, it is possible to spend too little on oversight and management, resulting in other inefficiencies. Consider efforts to reduce fraud and abuse. Until 1996, Medicare had few resources to devote to such activities, but now the program can use trust fund monies to finance investigations that promise to save the program money. And although many analysts were initially skeptical, reductions in spending increases targeted by anti-fraud efforts suggest these activities have been quite successful in the basic Medicare program.

On the other hand, private plans have had a traditional advantage over Medicare in the area of efficiency because they can be arbitrary. That gives them the flexibility to react quickly. That is, if they see a troubling pattern in service delivery, they can simply decline to renew contracts with doctors or hospitals. Medicare needs more flexibility in this regard, but it is likely that it will always have to meet higher standards of due process. This constraint may make Medicare more costly in some areas, but it also protects providers and beneficiaries.

The most important source of growth in health care costs arises from increases in numbers of services used and particularly from the diffusion of new technology, often referred to as "intensity" of service use. Both Medicare and private plans have difficulty in sorting out appropriate and inappropriate care. Studies that have looked at these issues concluded that there is a substantial amount of overuse of care (e.g., Chassin et al., 1987; Winslow et al., 1988). But difficulty arises in pinpointing where it is occurring and how to control it. Absent good effectiveness and quality studies, many providers and patients view access to unlimited tests and procedures as one way to ensure quality. Americans have a strong belief in and taste for high technology.

One of the key issues is who patients trust to help them make decisions on the use of services. In the "old days" of traditional fee-for-service medicine and little oversight, the decision was largely left to physicians and patients. Their inclination, it is believed, was to use too many services. This criticism is often lodged against the traditional part of Medicare.

Managed care organizations (MCOs) ideally are designed to address these issues because they take on the responsibility for the cost of all health care services for a patient and are paid a predetermined amount for that patient. Positively managing care can be done through careful coordination and oversight, although few insurers have devoted the time and effort necessary

to do this well, and many loosely organized plans do not have the means to do so (Center for Studying Health Care Change, 1999). Another approach is to place barriers in the way of getting care: requiring preapproval for tests and procedures, requiring referrals before someone can see a specialist, or denying certain services, for example. Poorly managed care can mean underservice and undesirable rigidities in allowing access to care. Moreover, the public has become increasingly skeptical of active efforts in this area. The patients' bill of rights movement is one indication of interest in limiting how arbitrary private plans can be. Over time, progressive plans may be able to improve techniques for managing care, establishing a case for further privatization, but the evidence does not support greater effectiveness of private plans, compared with traditional Medicare. And private plans will have to overcome their clients' skepticism about the motivation behind limits on service use.

More Cautious Approach

It is useful to think about reform in terms of a continuum of options that vary in their reliance on private insurance, with periodic reassessments of how well such efforts are working. Few advocate a fully private approach with little oversight; similarly, few advocate moving back to 1965 Medicare with its unfettered fee-for-service and absence of any private plan options. In between are many possible variations. And even for those who would make fewer structural changes, this does not mean that nothing needs to be done with traditional Medicare. Indeed, more emphasis is necessary to find ways to improve efficiency and help coordinate care short of relying on private plans.

Further, although differences in approach to reform may seem technical or obscure, the details will determine how the program will change and how well beneficiaries will be protected. Perhaps the most crucial issue is the role of traditional Medicare. Under the current Medicare+ Choice arrangement, beneficiaries are automatically enrolled in traditional Medicare unless they choose to go into a private plan. Alternatively, in premium support approaches, traditional Medicare would become just one of many plans that beneficiaries choose among—likely paying a substantially higher premium if they choose traditional Medicare. But whatever changes are made, traditional Medicare is likely to be the "default" plan for many years. Some beneficiaries with substantial health problems will view private plans as unrealistic options. Older beneficiaries may simply be reluctant to adjust to a new system of care. Thus, there needs to be a strong commitment to this part of the program. For the time being, there cannot and should not be a level playing field between traditional Medicare and private plans, because this would likely lead to traditional Medicare being priced beyond the means of many. Penalizing those who remain in traditional Medicare would run directly counter to the goal of protecting the most vulnerable.

The usual defense of a "choice of plans" approach is that payments from Medicare will be adjusted for risk and that will solve any problems that beneficiaries face including keeping the premiums for traditional Medicare in check. But there is considerable work left to be done on improving such risk-adjustment mechanisms. The solution to risk selection is to find ways that give plans incentives to treat sicker beneficiaries. But thus far, private

plans have resisted a greater reliance on such risk adjustment, and even experts often question whether the tools at hand are sufficient to move quickly to a greater reliance on private plans.

Further work is also needed on other provisions of the Balanced Budget Act of 1997 (BBA) if private plans are to play a larger role in Medicare. For example, private plans are currently up in arms over the levels of payment established under the BBA to make managed care a money-saver for Medicare. They want to maintain the extra benefits they have been able to offer as a result of overpayments. And planned demonstrations of competitive bidding have met opposition from insurers and beneficiaries alike (Nichols, 2000). Consumer education efforts also need to be more successful if beneficiaries are to make sound choices about private plans.

Better norms and standards of care are also needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management, and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared. Private plans can develop some innovations on their own, but in much the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems—exactly the population that many private plans seek to avoid.

Finally, it is not clear that there is a full appreciation by policymakers or the public at large of the consequences of a competitive market. If there is to be choice and competition, some plans will not do well in a particular market, and they will leave. Withdrawals should be expected; indeed, they are a natural part of the process of weeding out uncompetitive plans that cannot attract enough enrollees or establish good provider networks. In fact, if no plans ever left, that would likely be a sign that competition was not working well and that plans were overpaid.

But plan withdrawals result in disruptions and complaints by beneficiaries—much like those now occurring under the Medicare+Choice withdrawals that have occurred over the last 3 years. In those cases, beneficiaries who must change plans may have to choose new doctors, learn new rules, and/or pay more for extra benefits. In response, there has been strong political sentiment for keeping Federal payments higher than a well-functioning market would require, reducing any potential savings from relying on private plans.

Other Reform Issues

Although most attention on reform focuses on restructuring options and the benefit package, other key issues also arise, including age of eligibility, beneficiary contributions, and the need for more general financing. Even after accounting for changes that may improve the efficiency of the Medicare program through either structural or incremental reforms, the costs of health care for this population group will still likely grow as a share of GDP. That will mean that the important issue of who will pay for this health care—beneficiaries, taxpayers, or a combination of the two—must ultimately be addressed.

Age of Eligibility

Proposals to raise the age of eligibility for Medicare are offered to reduce the size

of the beneficiary population. Life expectancy has increased by more than 3 years since Medicare's passage in 1965, offering one justification for delaying eligibility (National Center for Health Statistics, 2000). And if people do begin to work longer, delaying their retirement, this option becomes more viable.

About 5 percent of Medicare beneficiaries are age 65 or 66. If the age of eligibility were increased to 67, however, savings would be substantially less—likely in the range of 2 to 3 percent of Medicare's overall spending—because persons in these age groups have lower Medicare costs than other beneficiaries. This is particularly the case because those age 65 or 66 who became eligible as disabled beneficiaries would stay on the Medicare roles (Waidmann, 1998).

But this approach also has disadvantages. Without private insurance reform, those out of the labor force might find it difficult to obtain insurance. Employers will face higher insurance costs if they provide retiree benefits to fill in the gaps of a rising age of eligibility. Alternatively, they might cut back on coverage, increasing the numbers of persons who would have to pay on their own or go uninsured. As a consequence, if the numbers of uninsured rise, placing burdens on public hospitals, and if the costs of producing goods and services rise to pay greater retiree health benefits, and if the number of young families supporting their older relatives increases, we will be just as burdened as a society. Thus, we will not have solved anything, although the balance on the Federal Government's ledgers will improve.

Beneficiaries' Contributions

Some piece of a long-term solution probably will (and should) include further increases in contributions from beneficiaries beyond what is already scheduled to go into place. The question is how to do so fairly. Options for passing more costs of the program onto beneficiaries, either directly through new premiums or cost sharing, or indirectly through options that place them at risk for health care costs over time, need to be carefully balanced against beneficiaries' ability to pay. Just as Medicare's costs will rise to unprecedented levels in the future, so will the burdens on beneficiaries and their families. Even under current law, Medicare beneficiaries will be paying a larger share of the overall costs of the program and more of their incomes in meeting these health care expenses (Moon, 1999).

One option is an income-related premium where higher income persons pay a greater share of Medicare's costs. Tying premiums to income makes sense on grounds of equity, but may be difficult to achieve in practice. Administrative costs would have to rise substantially. But more important, such approaches generate only limited new revenues unless the income thresholds are set very low. There simply are not enough high-income elderly persons for this option to "solve" the problem.

An alternative income-related approach would treat Medicare benefits—all or in part—as income and subject to the Federal personal income tax. This is analogous to taxing Social Security, although more complicated because these benefits are received "in kind" and are not traditionally viewed as income. Taxation of benefits would not only raise revenue but also make beneficiaries more aware of the "value" of Medicare benefits. However, this option would add considerably to Medicare's complexity, and critics argue that it is unfair to tax some in-kind benefits and not others.

Additional Public Financing for Medicare

Ultimately, the issue of who will pay must be divided between beneficiaries and tax-

payers. Even with higher beneficiary contributions and more efforts at improving the efficiency of the program, the long-run costs of Medicare will require additional public funds (Gluck and Moon, 2000). Because the population currently served by Medicare will grow to more than one in every five Americans, as a society we will need to face up to the costs of financing health care, either through the Medicare program or privately. Reducing Medicare's population or benefits will shrink government liabilities but do little to change the liabilities that society must face.

CONCLUSION

Medicare is likely to face many new challenges in the future, but it makes sense to consider previous accomplishments and the goals set in place in the original legislation in assessing what should be done next. Medicare cannot and should not remain the same as it was in 1966 or 1999, but reform efforts need to be carefully considered as to what should be done and at what pace.

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Health Care for the Poor: Medicaid at 35

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Over its 35-year history, Medicaid has grown from a program to provide health insurance to the welfare population to one that provides health and long-term care (LTC) services to 40 million low-income families and elderly and disabled individuals. Despite its accomplishments in improving access to health care for low-income populations, Medicaid continues to face many challenges. The future of Medicaid as our Nation's health care safety net will be determined by Medicaid's ability to broaden health coverage for the low-income uninsured, secure access to quality care for its growing beneficiary population, and manage costs between the Federal and State governments.

INTRODUCTION

When Medicaid was enacted as Title XIX of the Social Security Act in 1965, it was conceived as an important new form of Federal assistance to States to improve health care services for the Nation's needy welfare population. Over its 35-year history, the program has grown into a major component of our Nation's social safety net, evolving from a program primarily covering those who qualified for cash assistance to become an essential provider of health and LTC coverage for millions of low-income Americans.

Today, Medicaid covers more than 40 million low-income people at a cost of $169 billion to the Federal and State governments that finance it (Urban Institute, 2000). Medicaid has brought expanded health coverage for our poorest families, the elderly, and disabled populations, which in turn has led to measurable gains in access to care and improved health outcomes for the low-income population.

Since its enactment, Medicaid has also been the subject of public debate. The program has been criticized for the limits of its reach in providing health insurance to the poor, its ties to the welfare system and image problems, its variations across States, and the fiscal burdens imposed on Federal and State budgets as the program has grown in scope and spending (Rowland, 1995). These debates over Medicaid's role and structure continue, particularly as proposals to extend coverage to our growing uninsured population bring Medicaid again to the forefront of the policy debate. By examining Medicaid's role today as a safety net for the health and LTC needs of low-income Americans and its evolution, accomplishments, and challenges, we provide an overview of what we have learned about financing and delivering care to the poor through Medicaid and assess the implications for future directions.

MEDICAID TODAY

Today, Medicaid is the source of insurance for more than 1 in 7 Americans, accounts for 15 percent of our Nation's spending on health care, and is the major source of Federal financial assistance to the States, accounting for 40 percent of all Federal grant-in-aid payments to States

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(Kaiser Commission on Medicaid and the Uninsured, 1999a). From its roots as a program to help States cover their welfare populations, Medicaid has developed into a program that addresses the needs of low-income families, the elderly, and those with chronic, disabling health conditions. In these multiple roles, Medicaid is configured and operated somewhat differently in each of the 50 States and the District of Columbia.

Medicaid is a health insurance program that insures 21 million children and 8.6 million low-income adults. (Unless otherwise noted, all spending and enrollment data are based on unpublished Urban Institute analysis of HCFA-2082 and HCFA-64 reports [Urban Institute, 2000].) The program covers one in four American children and 40 percent of all births (Kaiser Commission on Medicaid and the Uninsured, 1999a). For most of the families covered through Medicaid, private health insurance is unavailable or unaffordable; with Medicaid, they gain access to a broad range of medical, dental, vision, and behavioral health services, including preventive care, acute care, and LTC, with little or no cost sharing.

Medicaid is also an acute and LTC support system for nearly 7 million low-income people with severe disabilities, ranging from people with physical impairments to those with severe mental or emotional conditions to those with specific disabling conditions, such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). For many, private insurance coverage does not cover necessary services, is not available due to preexisting condition exclusions, or is simply prohibitively expensive. Medicaid coverage provides an essential link to a broad array of services in the community or in institutions. Currently, Medicaid is the source of coverage for one in five nonelderly persons with a specific, chronic disability who live in the community and is the single largest source of public financing for HIV/AIDS-related care (Schneider, Strohmeyer, and Ellberger, 2000; Westmoreland, 1999).

For nearly 6 million low-income Medicare beneficiaries, Medicaid serves as a supplementary insurance program. Medicare's gaps in benefits and financial obligations can impose significant financial burdens on low-income beneficiaries, many of whom have more extensive health care needs than the average beneficiary but cannot afford costly private coverage to supplement Medicare (Rowland and Lyons, 1996). Medicaid provides additional coverage for services not covered by Medicare (notably, prescription drugs and LTC) and helps to cover Medicare's premiums and cost-sharing requirements.

For disabled and elderly low-income people, Medicaid is more than a health insurance program: It is also the only significant public program providing financing for LTC, covering home and community-based services, and providing institutional care. Serving both the very poor and those with higher incomes who have incurred significant health and LTC expenses, Medicaid covers 70 percent of nursing home residents and nearly one-half of nursing home costs nationwide (Niefield, O'Brien, and Feder, 1999). Medicaid's coverage of institutional care assists beneficiaries with those extremely expensive services and also helps to promote high-quality care by tying payment to quality standards. Medicaid's coverage of home and community-based services, as well as other non-medical social and supportive services, also allows many with LTC needs to remain in the community.

Medicaid is also a financing system for the Nation's safety net of clinics and hospitals that serve low-income and uninsured populations. In addition to its rules that

guarantee payment of clinic providers, Medicaid, through its disproportionate share hospital (DSH) program, makes supplemental payments available to institutions that serve a large portion of low-income and uninsured patients. Medicaid's financing is crucial to ensuring the solvency of many of these providers, providing 41 percent of revenues for safety-net hospitals and 34 percent of revenues for community health centers (National Association of Public Hospitals and Health Systems, 1996; Kaiser Commission on Medicaid and the Uninsured, 2000). Medicaid is also a key third-party resource to supplement funding for State public health efforts, such as tuberculosis control and family planning programs, as well as other Federal programs, such as the Ryan White Care Act and the Maternal and Child Health Block Grant.

From the perspective of who is served, Medicaid is predominantly a program assisting low-income families, but from the perspective of how Medicaid dollars are spent, Medicaid funds primarily serve the low-income aged and disabled population. Adults and children in low-income families make up 73 percent of enrollees but account for only 25 percent of spending. In contrast, the elderly and disabled account for 27 percent of enrollees and the majority (67 percent) of spending, largely due to their intensive use of acute care services and the costliness of LTC in institutional settings. In 1998, the average per capita cost for a child covered by Medicaid was $1,225, almost all of which went to basic acute care, while the corresponding figures for the disabled and elderly were $9,558 and $11,235, respectively, a significant portion of which went to LTC services (Urban Institute, 2000).

EVOLUTION OF MEDICAID

The 1965 enactment of Medicaid was a tremendous step forward in financing and providing health care to many segments of the poor population. Modeled on the 1960 Kerr-Mills legislation providing Federal matching grants to States for care of the indigent aged, Medicaid initially offered the States Federal matching grants to finance medical care for the poor receiving welfare payments. Coverage—and the availability of Federal matching funds—was linked to the State-determined income levels for welfare assistance and to the categories of eligibility for welfare: primarily, single parents with dependent children, and aged, blind, and disabled individuals. Income and asset standards for Medicaid coverage were tied to State-based welfare policy, with eligibility rules and processing done by the welfare offices.

From these early roots, Medicaid evolved in several directions: to become a broader source of health insurance coverage for children and pregnant women, to take on additional responsibility for coverage of the low-income aged and disabled population, and to provide assistance with Medicare premiums and cost sharing for low-income Medicare beneficiaries. Underlying each of these expansions was the goal of improving coverage for a vulnerable part of the low-income population by, in most cases, Federal legislation first giving States the option to broaden their program and later requiring that States cover those whose income was below a federally established floor (Rowland et al., 1992).

In the case of low-income families, Medicaid has evolved by extending coverage to low-income children and pregnant women regardless of cash-assistance status

or family situation. Federal legislation in the 1980s and 1990s broadened eligibility beyond traditional welfare populations by requiring coverage of children and pregnant women in either single- or two-parent families as long as they were income-eligible, thus ending the categorical restrictions that focused eligibility on single-parent families. Medicaid coverage for pregnant women and children was set at uniform Federal standards tied to the poverty level, with States given the option to establish higher income standards for these groups.

With welfare reform in 1996, the link between cash assistance and Medicaid eligibility was officially severed. The welfare law left Medicaid eligibility levels intact but also established a new Medicaid eligibility category (section 1931) through which States had broad authority to extend Medicaid coverage to low-income families. In 1997, the passage of the State Children's Health Insurance Program (SCHIP) further redefined Medicaid as a health insurance program distinct from welfare, providing funds for States to expand coverage to children up to at least 200 percent of the Federal poverty level. This program also gave States the option of either directly expanding Medicaid or creating a new separate program for children from families with incomes above Medicaid levels.

This broadening program scope for low-income families is reflected in trends in enrollment and spending. The number of children and adults enrolled in Medicaid increased substantially, from 9.8 million children and 4.6 million adults in 1985 to 21 million children and 8.6 million adults in 1998. The majority of that increase was comprised of enrollees receiving Medicaid only (as opposed to those also receiving cash assistance). Although low-income families were the fastest growing eligibility group within the Medicaid program, they accounted for only a small amount of the growth in spending during this time because of their relatively low per capita costs (Feder et al., 1993).

Medicaid also evolved as a program to assist low-income elderly and disabled populations. The 1972 amendments to the Social Security Act were a primary step in this evolution. First, by establishing a Federal program for cash assistance for the aged, blind, and disabled (Supplemental Security Income, or SSI), with national eligibility criteria and income standards, State variations in Medicaid coverage of these groups were largely replaced with a uniform national minimum benefit and a national eligibility standard, which increased the number of people covered. Second, changes in the Medicaid benefits package expanded the range of covered services for the disabled and elderly by adding services furnished by intermediate care facilities and intermediate care facilities for the mentally retarded (ICFs/MR) as an optional benefit eligible for Federal matching funds. Subsequent additions to the Medicaid benefits package, particularly in home and community-based LTC services, further expanded the role of the program for these populations in the 1980s.

Although enrollment of the elderly and disabled in Medicaid increased more moderately than that for low-income families, these groups continued to be a major spending focus of the program because of their heavy reliance on acute care and, more importantly, utilization of LTC services. As a result of Medicaid's expanding role for the low-income elderly and disabled, the program's total LTC spending accounted for nearly 40 percent of Medicaid's total expenditures by 1998 (Urban Institute, 2000). (LTC services include nursing facilities, ICFs/MR, mental health, home health services, and personal care support services.) Medicaid

spending on nursing home care, which covered just 11 percent of national nursing home spending in 1966, helped fuel the growth of this industry and covered 48 percent of national nursing home spending by 1999 (Health Care Financing Administration, 2000). Medicaid's expanding role in financing LTC has in turn given the program a key role in setting quality standards in the area, enabling the Federal Government to use its purchasing power to implement comprehensive nursing home reform to raise standards for nursing home quality and establish protections for "spousal impoverishment" in the late 1980s.

A related expansion in Medicaid's role for the low-income elderly and disabled is its evolution as a Medicare supplement. As beneficiary financial obligations for Medicare coverage grew over time, Federal legislators looked to Medicaid to help provide financial protection to the lowest income Medicare beneficiaries. Since 1965, most Medicare beneficiaries receiving cash assistance through SSI (roughly 5 million) have been covered by Medicaid for Medicare premiums and cost sharing and additional benefits not covered by Medicare. Over time, assistance with Medicare's premiums and cost sharing has been extended to additional low-income Medicare beneficiaries through a series of incremental expansions. As health care costs rise, medigap costs increase, retiree coverage declines, and service delivery relies more and more on prescription drugs and LTC services, the importance of Medicaid's expanding role for Medicare beneficiaries becomes more and more evident.

IMPACT OF MEDICAID

To understand the full effect of Medicaid's contributions to health care in America, it is necessary to look at the impact that the program has on the individuals it serves. Over the past 35 years, the program has demonstrated the importance of health care coverage and achieved remarkable success in helping to close gaps in access to care for low-income groups. Prior to Medicaid's passage, the poor were essentially outside mainstream medical care, relying on the charity of physicians and hospitals and public hospitals and clinics for their care, and often facing discrimination in their attempts to access services. The difficulties associated with this patchwork of health services resulted in fewer services being provided to the poor compared with the non-poor, despite the fact that the poor are in poorer health (Rogers, Blendon, and Moloney, 1982). Medicaid has reshaped the availability and provision of care to the poor and helped to improve health status, access to care, and satisfaction with the health care system among the poor. The value of Medicaid is underscored by the contrast in outcomes between the poor with Medicaid and the uninsured poor, where studies consistently show that the uninsured lag well behind those with Medicaid, while those with Medicaid fare comparably to the privately insured (Lillie-Blanton, 1999). Children with Medicaid are only slightly less likely than privately insured non-poor children to have a regular source of care and reasonable access to care, but poor uninsured children face significant deficits (Lyons, 2000).

Medicaid has also played a significant role in reducing the financial burdens and barriers to care for low-income elderly and disabled Medicare beneficiaries. Comparisons of access to care for those solely dependent on Medicare coverage versus those with Medicaid or private supplemental insurance again show that Medicaid provides substantial assistance in reducing barriers for some of Medicare's poorest beneficiaries (Rowland and Lyons, 1996). Those with Medicare

only are more likely to delay care because of cost and less likely to have a regular source of care and use care than those with Medicaid as a supplement (O'Brien, Rowland, and Keenan, 1999).

As a safety net for the most vulnerable and needy Americans, Medicaid has faced the daunting challenge of serving low-income people whose health and social needs are extremely complex. This charge catapults Medicaid into many of our country's most difficult health and social issues: urban violence, teen pregnancy, substance abuse, and HIV/AIDS. In the face of these challenges, Medicaid has done a remarkable job of improving health care for millions of low-income Americans.

CHALLENGES FACING MEDICAID

Despite its 35 years of accomplishments in assisting the Nation's needy and vulnerable low-income populations, Medicaid remains a program struggling to meet its expectations within the constraints of Federal and State fiscal and policy differences. The future of Medicaid as our Nation's health care safety net will be determined by how well Medicaid is able to address the challenges of broadening health coverage for the low-income uninsured, securing access to quality care for its growing beneficiary population, and managing costs between the Federal and State governments.

Expanding Medicaid's Reach

As the primary source of financing and coverage for the low-income population, Medicaid has been a critical force in moderating the growth in America's uninsured. The share of the non-elderly population with Medicaid coverage rose each year from 1987 through 1995, helping to offset loss of employer-sponsored coverage and thus restraining growth in the uninsured population (Hoffman and Schlobohm, 2000). Although recent years have seen a decline in Medicaid enrollment among adults and children, in the absence of the expansions of coverage, we would see as many as 10 million more low-income children added to the 11 million children uninsured today (Lyons, 2000).

With the availability of additional resources to help provide insurance to children in working families through SCHIP, there are even greater opportunities to reduce the problem of uninsurance among our Nation's poorest families. In providing States with the option of covering all children in families with incomes up to 200 percent of the poverty level (in many States, this limit is even higher), Medicaid in combination with SCHIP could extend health insurance to all low-income children—an expansion that would cover 19 percent of the total uninsured population in America today (Feder and Burke, 1999). As of December 1999, nearly 2 million previously uninsured children were covered under SCHIP in addition to the 21 million children with Medicaid coverage (Smith, 2000).

Although Medicaid and SCHIP have been instrumental in providing health insurance coverage to low-income children and hold the promise of extending coverage in the future, the ability of the programs to reach their full potential is undermined by barriers in outreach and enrollment. Nearly one-half of uninsured children are eligible for Medicaid or SCHIP but are not enrolled (Kaiser Commission on Medicaid and the Uninsured, 1999b). Some may be unaware that they are eligible for coverage, and others may not be able to navigate the eligibility process. The majority of parents of eligible children attach a high level of importance to having coverage and say that Medicaid and SCHIP

are valuable programs but want the eligibility process simplified and made more suitable to working parents' schedules (Perry et al., 2000). The barriers to enrollment are not inherent to the Medicaid program but are problems with practical, feasible solutions that some States are trying and all States can implement.

The implementation of welfare reform has raised another set of obstacles to Medicaid's ability to broaden coverage to the low-income population. The welfare reform legislation of 1996 severed the automatic link between Medicaid and welfare eligibility and has contributed to the apparent loss of Medicaid coverage for many low-income adults and some of their children (Lyons, 2000). Low-income families moving from welfare to the workplace are still eligible for Medicaid, but many appear to lose their Medicaid benefits in the transition. Studies show that 1 year after leaving welfare, 49 percent of females and 29 percent of children formerly covered by Medicaid were uninsured, largely as a result of confusion over eligibility rules and systems errors (Garrett and Holahan, 2000). In addition, as fewer families apply for cash assistance, many do not know they are still eligible to obtain Medicaid coverage. This confusion has contributed to the recent declines in Medicaid enrollment and helped boost the number of uninsured Americans despite our robust economy.

Medicaid's ability to serve the low-income uninsured is also severely constrained by limits on Federal matching funds, especially for coverage of low-income adults without children. Though the program is slowly advancing beyond its welfare roots, many eligibility categories are still targeted primarily to children, pregnant women, and those with disabilities. For adults who are not pregnant or disabled, eligibility is limited to parents with very low incomes (at standards set at former welfare levels—on average, about 41 percent of the poverty level, or less than $6,000 for a family of 3). In 32 States, a parent working full-time at minimum wage earns too much to qualify for Medicaid coverage (Guyer and Mann, 1999). Adults without children are ineligible for Medicaid coverage, no matter how poor, unless they qualify as disabled individuals. These limits on eligibility categories are one reason that 40 percent of poor and 32 percent of near-poor females and 50 percent of poor and 40 percent of near-poor males are uninsured (Hoffman and Schlobohm, 2000).

States have the ability to use the Medicaid program to extend coverage more broadly to parents and, in some cases, childless adults, but coverage remains limited. Eighteen States now have Federal waivers of Medicaid law (known as section 1115 waivers) that allow them to experiment with changes in the scope and structure of their Medicaid programs and to use Federal dollars to cover additional people. With welfare reform, States were also given a new mechanism (section 1931) that allows for expanded coverage of low-income families under Medicaid, but few States (10) have embraced the new option (Ku and Broaddus, 2000).

Medicaid's ability to reach and cover the uninsured is one of its most daunting challenges. Among the 44 million uninsured Americans, more than one-half have incomes below 200 percent of the Federal poverty level, and nearly two-thirds of the low-income uninsured are children and their parents (Hoffman and Schlobohm, 2000). As employer-based coverage for low-wage working families continues to decline, there is growing pressure on Medicaid to assist with their health insurance needs. Building on and improving Medicaid and SCHIP for children and extending coverage to their parents and

other low-income adults has the potential to reach nearly one-half of the uninsured population (Hoffman and Schlobohm, 2000).

Improving Coverage for Medicaid Beneficiaries

If Medicaid is to remain a successful program, it must ensure that it ably meets the health needs of the population it serves. On average, Medicaid enrollees are sicker than those with private insurance, require more care, and use more services. In many cases, they require highly specialized medical services or chronic care that is both expensive and difficult to manage. These populations and their complex service needs fall uniquely to Medicaid because this type of coverage generally falls outside the purview of private insurance policies and Medicare.

To address challenges in service delivery, many States are now moving to enroll increasing numbers of their Medicaid populations in managed care. As States have gained greater flexibility from the Federal Government to utilize managed care in their Medicaid programs, enrollment has grown from 2.7 million beneficiaries enrolled in Medicaid managed care plans in 1991 to 16.6 million in 1998 (Kaiser Commission on Medicaid and the Uninsured 1999c). By 1998, more than one-half of all beneficiaries were enrolled in managed care, mostly concentrated among low-income families, though States are beginning to also enroll disabled and elderly populations. Managed care includes a range of plan types, from loosely structured networks of providers or gatekeeper models to full-risk, capitated plans, but much of the recent growth has been among full-risk plans.

This shift in Medicaid's delivery system to managed care has the potential to improve care by emphasizing preventive and primary care and providing care coordination through a clearly identifiable health care provider but can also raise problems with underservice in a needy population. To be effective and to preserve access to needed services, it is important to ensure that plans have provider networks in place, educate both providers and enrollees about managed care, and respond to the unique needs of the Medicaid population. Unless States monitor implementation carefully, commit additional resources to program management, and assess the adequacy of the quality of care provided by providers and plans, quality and availability of care could be compromised.

Payment levels, particularly in managed care arrangements, are an important aspect of service delivery. Operating under tight budget constraints, Medicaid has often paid providers at rates that are substantially below private sector rates—especially for physician services, where low rates have jeopardized willingness to participate. If Medicaid payments to managed care plans, especially capitated plans that are fully at risk, are set below market rates to achieve savings, the result may be poorly financed plans and poor quality care for Medicaid enrollees, with limited participation of mainstream plans.

In addition to the challenge of managed care implementation, Medicaid must also tackle the issue of meeting the needs of an aging population. In the next 30 years, the Medicare population is expected to nearly double, with major increases in the population over age 85—those at greatest risk of needing nursing home care. With this increase, the pressure on the Medicaid

program to assist the low-income elderly and disabled is likely to intensify. Moreover, if future Medicare program changes, such as the implementation of a new drug benefit, result in increases in Medicare premiums, deductibles, or cost sharing, new pressure will be placed on Medicaid to help low-income beneficiaries continue to meet Medicare's financial obligations.

Restraining Costs and Addressing State Diversity

One of the biggest challenges facing the Medicaid program is how to meet the growing need for health and LTC coverage within the constraints of Federal and State financing. Although Medicaid is jointly financed by the Federal and State governments, many of the basic coverage and provider payment decisions that determine overall expenditures are made at the State level. Because States make different decisions about whom to cover, what benefits to provide, and what to pay for services, the scope and cost of the program vary widely across States.

The program's spending history has shown much volatility in recent years, although spending patterns for Medicaid prior to the early 1990s showed lower annual growth than private health care spending, and current increases have substantially moderated. The requirement for States to match Federal dollars with State dollars has served as a constraint on overall spending but also motivates creative financing in the Federal and State fiscal battles. Provider taxes and donations, DSH payment policies, and other State innovative financing practices allowed States to accrue additional Federal financing in the early 1990s and dramatically increase Federal spending (Feder et al., 1993; Holahan and Cohen, 1996). Eliminating these practices that allow States to spend Federal dollars without commensurate matching funds from State revenues has helped to moderate current Medicaid spending, but such practices remain strong reminders of the tensions and the potential for cost shifting in a jointly financed program.

But beyond the financing tensions, split responsibility with State discretion over major aspects of program eligibility and coverage inevitably lead to differences across States. Medicaid is not a uniform national program for health care for the poor; where one lives determines the scope and availability of Medicaid coverage. In recent years, federally mandated expansions for pregnant women and children have leveled the playing field across States by establishing eligibility floors linked to the Federal poverty level. However, States still have the option to extend coverage to higher levels, vary the benefit package, and set payment levels for care.

A key question for the future is how many Federal dollars should be used to promote equity in coverage by income across the country and how much should go toward providing States funds that allow them the flexibility to develop programs tailored to State priorities that may differ from national objectives. Addressing differences across States is yet another challenge facing Medicaid.

FACING THE FUTURE

The evolution and current state of Medicaid provide valuable insights with which to confront these challenges. Above all, Medicaid has shown us that providing health insurance matters for the low-income population. It improves access to care and health outcomes and helps to close differentials in care by income. Expansion of Medicaid has helped to

increase coverage and reduce the growth in our uninsured population, providing valuable assistance to families whose limited resources make cost sharing and premiums financial barriers to care.

But we have also learned from Medicaid that links to welfare and the structural barriers that often accompany a means-tested program can limit the reach of the program. Medicaid's eligibility roots in welfare-based categories and income levels, as well as its reliance on the welfare system for eligibility determination and process, have created roadblocks for working families and have severely hampered the program's ability to reach its full potential as a health insurance program for low-income people. Moreover, State flexibility in setting income standards and eligibility has led to wide variations in coverage across States. The future of the program and its effectiveness in addressing the high rates of uninsurance in the low-income population depend upon whether the program can be transformed into a health insurance program for low-income people, with simplified enrollment processes and forms, broader outreach, and eligibility that includes all low-income individuals, regardless of family status.

Any expansion of coverage through Medicaid also requires a continued commitment to making sure that the program can provide quality health care for its beneficiaries. Medicaid has shown us that, too often, a program for the poor is also a poor payer for health care services, leading to provider unwillingness to participate and creating access barriers for Medicaid beneficiaries. Providers of services to the Medicaid population need to be both adequately paid and monitored to ensure that mainstream medical care and high-quality LTC services are afforded to Medicaid beneficiaries. Wherever possible, differentials in payment levels between Medicaid and private insurers should be minimized and access to the broadest range of health providers in the community assured. In addition, our experience with Medicaid teaches us that meeting the health and LTC needs of the most vulnerable members of our society—those with serious and chronic illness and/or debilitating physical and cognitive limitations—is extremely complex. Solutions widely used in the private market, such as capitated managed care, pose special challenges to the Medicaid program and require additional resources and planning. Particularly as Medicaid's role for the elderly grows, better integration of acute and LTC services and improved coordination of Medicare and Medicaid coverage are essential.

Finally, Medicaid's 35 years also offer insights into the inherent complexity of Federal and State partnerships in programmatic and fiscal responsibility. The Medicaid experience shows that uniformity across States can only be achieved with Federal requirements for minimum income standards for eligibility or mandated rules for coverage. State flexibility over program design invariably leads to major variations in coverage and program scope across the States. Moreover, shared fiscal responsibility provides both levels of government with an incentive to restrain costs to stay within budget but also inevitably leads to tension over who pays and how much. Medicaid has in fact shown us that States can be quite creative in finding ways to maximize Federal dollars and reducing the need for State matching funds. Clarification of goals and responsibilities between the Federal and State governments over program eligibility and scope of services and fiscal accountability would do much to improve the operation of Medicaid at both the Federal and State levels.

This experience tells us that at 35, Medicaid is a vital and important program to millions of low-income Americans—an essential part of our Nation's safety net for its poorest and most vulnerable population. The limitations in Medicaid's scope and the flaws in its operation are not without solutions. What is needed for the future is that we recognize Medicaid's strengths and build on this base to address its current limitations, forging an even stronger program to meet the growing demands of the new millennium.

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Trends in Medicare Expenditures and Financial Status, 1966-2000

Richard S. Foster, F.S.A.

In this article, the author reviews expenditure growth trends over Medicare's 35-year history and comments on how the program's long-range financial outlook has changed over time. The author focuses on the various legislative, economic, and demographic factors that have affected expenditure growth and financial status. In addition, Medicare's share of total U.S. health costs is briefly reviewed. In an appended comment, the author considers whether the impact of the Balanced Budget Act of 1997 (BBA) was greater than intended by Congress and the Administration. The author concludes with a plea for greater attention to correcting the projected long-range deficits for the Hospital Insurance (HI) Trust Fund.

INTRODUCTION

For 35 years, the Medicare program has helped cover the costs of medical care for most persons age 65 or over and (after 1972) for certain disabled persons. It is the Nation's second-largest social insurance program, with total expenditures in calendar year 2000 estimated to reach $228 billion. (For comparison, Social Security Old-Age, Survivors, and Disability Insurance [OASDI] expenditures are expected to total $410 billion in 2000.) The purpose of this article is to review the trends in Medicare expenditures since the program began operations in 1966 and to comment on how its long-range financial outlook has changed over time.

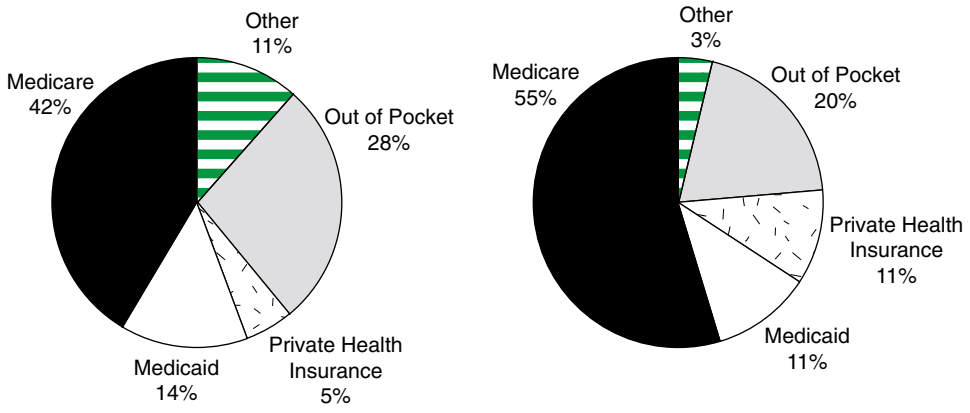
The author is with the Health Care Financing Administration (HCFA). The views expressed in this article are those of the author and do not necessarily reflect the views of the Health Care Financing Administration.

Medicare was enacted in 1965 as a sweeping compromise among competing proposals. Consequently, many of its coverage, eligibility, benefit, and financing provisions differ substantially between Medicare Part A (HI) and Part B (Supplementary Medical Insurance, or SMI). Because the circumstances leading to this outcome are not well known, Medicare's first chief actuary, Robert J. Myers, has graciously provided a very interesting account of these events, which appears in the ensuing article of this 35th Anniversary issue (Myers, 2000). A description of the HI and SMI provisions is also available in Hoffman, Klees, and Curtis (2000).

In 1967, the first full calendar year of operation for Medicare, program expenditures accounted for approximately 9.7 percent of all health expenditures in the United States (Health Care Financing Administration, 2000). This proportion increased steadily from 1972 to 1983 before stabilizing in the vicinity of 16 percent in 1984-1993. In recent years, the percentage increased further, reaching 19.4 percent in 1997, but it has declined somewhat following the BBA to an estimated 18.4 percent in 2000. From 1967 through (estimated) 2000, Medicare expenditures per beneficiary increased at an average annual rate of 10.0 percent, while the corresponding figure for per capita national health expenditures is an estimated 9.3 percent. Although these average growth rates are roughly similar, they have diverged significantly on occasion within this period (Levit et al., 2000).

Figure 1

Sources of Funding for Personal Health Care Expenditures for Persons 65 or Over, 1968 and 1997



Fiscal Year 1968
Total health expenditures in 1968 = $12.4 billion
Average per capita expenditures = $647

Fiscal Year 1997
Total health expenditures in 1997 = $301 billion
Average per capita expenditures = $8,937

SOURCES: For 1968: (Cooper, Worthington, and McGee, 1976). For 1997: Health Care Financing Administration, Office of the Actuary.

For the population age 65 or over, Medicare paid for about 42 percent of total personal health care expenditures in fiscal year 1968, as shown in Figure 1 (Cooper, Worthington, and McGee, 1976). By calendar year 1997, this percentage had increased to 55 percent, with most of the balance covered by Medicaid, private health insurance, and the beneficiaries' own out-of-pocket payments. (These figures are not strictly comparable, because the percentages for 1968 are for everyone in the population at ages 65 or over, whereas those for 1997 are only for Medicare beneficiaries at such ages. Given that nearly everyone over age 65 was covered by Medicare in 1967, the difference has little impact on the comparison.) Medicare's increased share is in part attributable to the Part B deductible, which was $50 in 1968 and has been increased only three times since then, to $100 currently. Because covered costs increased far more rapidly, a greater proportion of covered costs is in excess of the deductible and is therefore reimbursable by Medicare. In 1968, only 38 percent of beneficiaries had Part B costs in excess of the deductible, but by 1997, this proportion had risen to 87 percent (Gornick, 1976; Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, 2000). Medicare's increasing share has also reflected rapid growth in the prices, utilization, and intensity of such covered services as physician, skilled nursing, and home health care. On the other hand, in some years, certain noncovered costs—such as for prescription drugs and long-term nursing home care—increased more rapidly than health costs generally, thereby adding to the portion funded by non-Medicare sources. Overall, the trend has been toward a greater Medicare share of the total personal health care costs of the aged.

Also noteworthy in Figure 1 is the relatively small decline in Medicaid outlays as a percentage of total personal health care expenditures for beneficiaries over age 65. The proportion of older persons with

incomes below the poverty thresholds (who are the most likely to be eligible for Medicaid) fell from roughly 16 percent in 1966 to 11 percent in 1997 (Gornick et al., 1985; Social Security Administration, 1999). The impact of this trend on Medicaid expenditures was largely offset, however, by expansions in coverage, including the creation of Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs). (Medicaid pays the Medicare premium[s] on behalf of QMBs and SLMBs and also the beneficiary cost-sharing liabilities for QMBs.) In addition, during this period, Medicaid absorbed a substantial portion of the rapidly increasing expenditures for nursing home care.

The proportion of health care service costs paid directly by beneficiaries has declined significantly since the beginning of the program, from about 28 percent in 1968 to 20 percent currently. This change is attributable primarily to the increased shares covered by Medicare and private health insurance. It should be noted, however, that beneficiaries' premium payments to Medicare and private insurance plans are not included in the out-of-pocket costs shown here.

Review of Medicare Expenditure Trends

Figure 2 shows aggregate annual Medicare expenditures for calendar years 1966-2000. (Medicare began benefit payments in July 1966; therefore, the amount shown for the first year reflects only 6 months. The amount shown for 2000 is an estimate, based on data through July 2000.) The expenditures are shown using a semi-log scale to highlight periods of faster or slower growth, indicated by the slope of the expenditure curve. As shown in Figure 2, Medicare expenditure growth has been fairly volatile, ranging from very fast growth at program startup to slight decreases in expenditures in 1998-1999 and, until the last few years, tending to average at least 10 percent per year.

Five subperiods of relatively faster or slower Medicare growth trends are identified in Figure 2. Over the years, expenditure growth has been affected by many factors, including:

- Increases in the number of beneficiaries.
- Legislative and regulatory changes (including both program expansions and provisions designed to slow cost increases).
- General economic factors, including the rates of inflation and wage growth.
- Changes in the utilization and intensity of health care services covered by Medicare.[1]

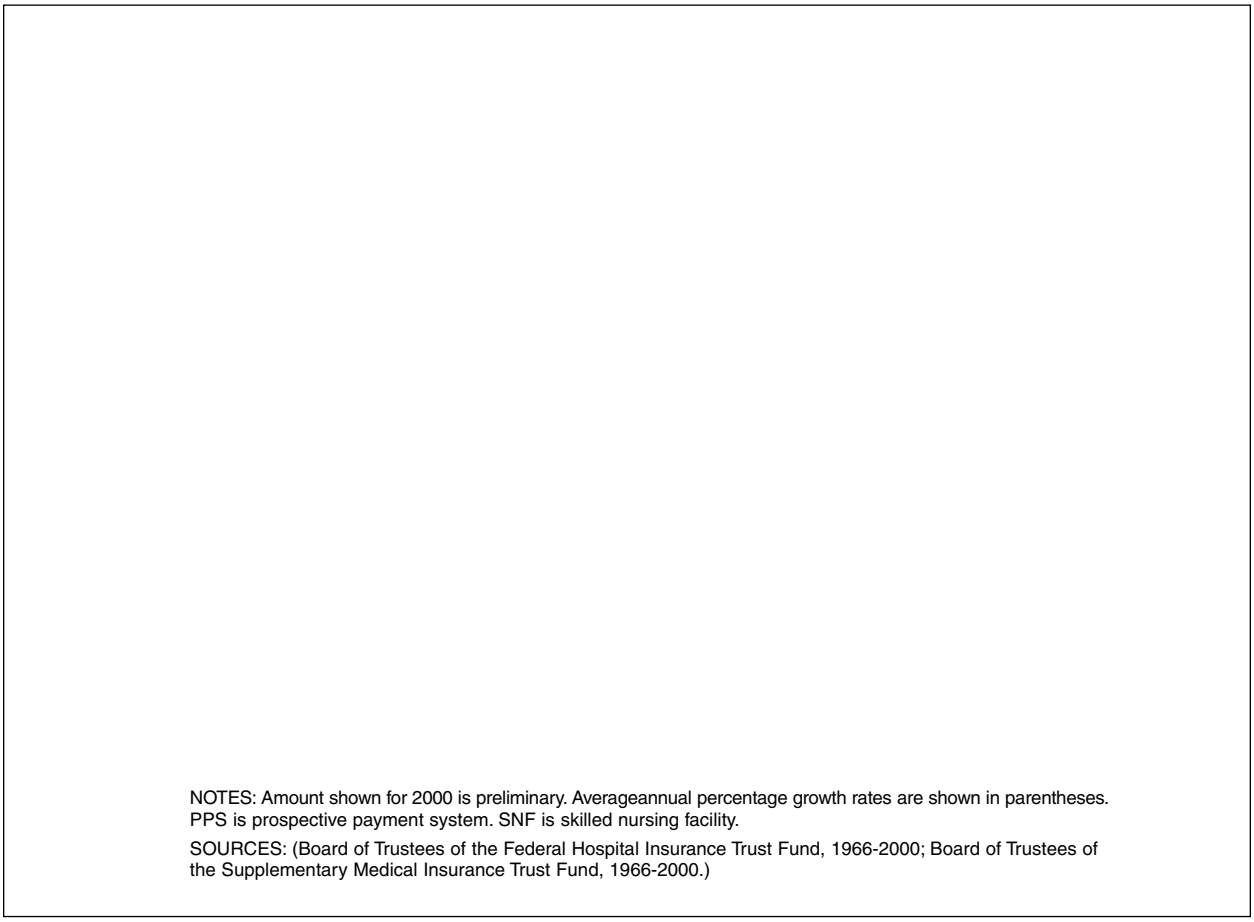
The primary factors affecting Medicare expenditure growth rates in each of the five subperiods are summarized in Table 1. More detail on these factors is available in Gornick (1976), Gornick et al. (1985 and 1996), Helbing (1993), Christensen (1991), and Davis and Burner (1995).

The very low average growth rate during 1998-2000 stands in marked contrast to the significantly higher rates experienced throughout Medicare's prior history. This change reflects three very favorable developments affecting Medicare expenditure growth: the implementation of the BBA, the impact of intensified efforts to address fraud and abuse in the Medicare program, and very low rates of general and medical inflation. The overall average growth rate of only 2.2 percent during this period, however, reflects slight declines in expenditures in 1998 and 1999, together with a significant rebound of an estimated 6.9 percent in 2000. Although detailed data are

[1] "Intensity" refers to the average complexity of the services reimbursed by Medicare. It can reflect not only technological progress, such as the ability to do open-heart surgery, but also changes in accounting practices and the coding of claims by health care providers to optimize Medicare payments.

Figure 2

Medicare Expenditures and Average Annual Rate of Growth, by Era: 1966-2000



NOTES: Amount shown for 2000 is preliminary. Averageannual percentage growth rates are shown in parentheses. PPS is prospective payment system. SNF is skilled nursing facility.

SOURCES: (Board of Trustees of the Federal Hospital Insurance Trust Fund, 1966-2000; Board of Trustees of the Supplementary Medical Insurance Trust Fund, 1966-2000.)

not yet available for calendar year 2000, the expenditure growth in that year is associated with the Balanced Budget Refinement Act of 1999, which eased certain of the provisions enacted in 1997, and with increased utilization of services.

The factors underlying Medicare expenditure growth can be analyzed in greater detail by considering HI and SMI separately. Figure 3 shows annual increases in HI expenditures by (1) growth in the number of beneficiaries, (2) general inflation, (3) medical inflation in excess of general inflation, and (4) all other factors. This last category includes any increases in the utilization of covered services and in the intensity of services. Any errors in measurement of price change will also be reflected in the "all other factors" category, as discussed later.

The number of HI beneficiaries has generally increased by roughly 2 percent annually, with two notable exceptions. First, above-average growth occurred in 1973 and the following several years, when disabled individuals and persons with end stage renal disease became eligible. Also, during the most recent few years, annual enrollment growth dropped to about 1 percent as a result of the relatively low birth rates experienced 65 years earlier during the Great Depression. As shown in Table 2, until recently, enrollment growth for aged beneficiaries had been remarkably stable in the 2-percent range, while growth in the number of disabled beneficiaries had fluctuated dramatically and generally exceeded the aged growth rate by a significant margin. This latter variation is attrib-

Table 1

Key Factors Underlying Periods of Faster or Slower Medicare Expenditure Growth: 1966-2000

Calendar Years	Average Annual Percent Increase	Type of Factor: Cost-Accelerating	Type of Factor: Cost-Decelerating
1966-1969	32.3	Program startup; pent-up demand; increased access for minorities; rapid increases in hospital costs and SNF utilization.	None of consequence.
1970-1973	10.0	Growth in outpatient hospital costs.	Imposition of wage and price controls; 1973 increase in Part B deductible; declining skilled nursing facility utilization.
1974-1982	20.0	Eligibility extended to certain disabled persons and individuals with end stage renal disease (effective July 1973); removal of wage and price controls, and rapid general and medical inflation; increased physician, outpatient hospital, and home health care utilization; inpatient hospital intensity growth.	Declining skilled nursing facility utilization.
1983-1997	9.8	Major increases in skilled nursing utilization and cost per day and in home health services (beginning in late 1980s); increases in inpatient case mix and outpatient utilization.	Substantial decline in general inflation; prospective payment system for inpatient hospital services (effective October 1983), and reductions in inpatient payment updates; 22- to 30-month freeze on physician payment levels (effective July 1984); physician fee schedule and volume performance standards (phased in 1992-1996); 1982 and 1990 increases in Part B deductible.
1998-2000	[1]2.2	Balanced Budget Refinement Act of 1999.	Balanced Budget Act of 1997; intensified efforts to combat fraud and abuse; very low general and medical inflation.

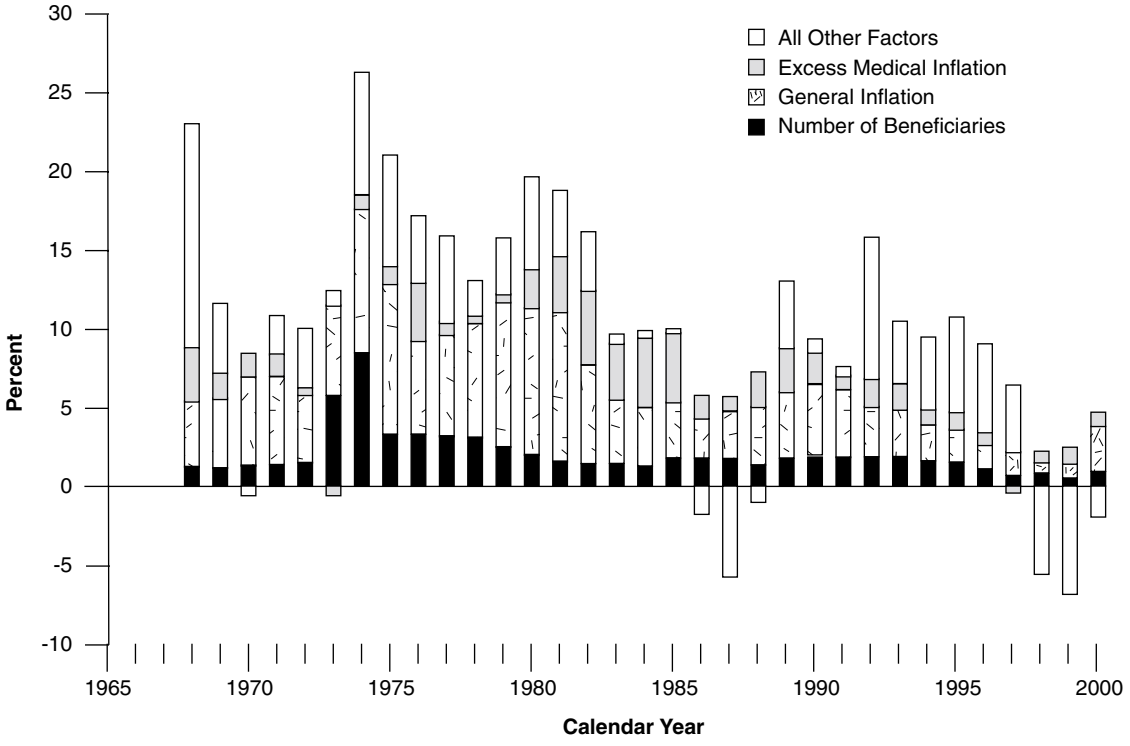
[1] Based on preliminary estimate of increase for 2000.

NOTE: SNF is skilled nursing facility.

SOURCES: (Gornick, 1976; Gornick et al., 1985 and 1996; Helbing, 1993; Christensen, 1991; Davis and Burner, 1995; Board of Trustees of the Federal Hospital Insurance Trust Fund, 1966-2000; Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, 1966-2000.)

Figure 3

Annual Increase in Hospital Insurance Expenditures, by Source of Growth: 1968-2000



NOTES: Growth rates for 2000 are preliminary estimates. Refer to text for definitions and limitations of price measures.
SOURCE: Health Care Financing Administration, Office of the Actuary, 2000.

utable in part to economic factors but is also associated with changes in law, regulations, and administrative policy for the Social Security Disability Insurance program (Zayatz, 1999). (Persons under age 65 qualify for HI benefits if they have received Social Security or Railroad Retirement disability benefits for at least 2 years.)

General inflation is a major contributing factor to growth in health care costs, as one would expect. The very rapid inflation associated with the two oil price shocks in 1973-1975 and 1979-1980 is a prime example. Inflation fell substantially following the 1981-1982 economic recession and rebounded temporarily during the Gulf War in 1989-1990. In 1992 and later, inflation was relatively low, although it rose somewhat in 2000, again as a result of energy costs.

The prices paid for medical services have frequently increased at a faster rate than general inflation. In Figure 3, this excess medical inflation is shown as the difference between a chain-weighted index of personal health care costs and the chain-weighted price index for the gross domestic product (Bureau of Economic Analysis, 2000).[2] Such excess price growth has fluctuated considerably since 1966 but was generally above 2 percent per year during the period 1983-1993. This factor has diminished significantly in the last few years.

The price measures used in this analysis are intended to provide only a broad illustration of the impact of medical inflation on

[2] The chain-weighted index of personal health care price change was developed by Helen Lazenby in the Office of the Actuary, using (1) Medicare expenditures by type of service for the weights and (2) components of industrywide price indexes (such as the Consumer Price Index and Producer Price Index) by type of service.

Table 2

Average Annual Growth Rates in the Number of Aged and Disabled Medicare Beneficiaries[1]: 1967-2000

Calendar Years	Type of Beneficiary		
	Total	Aged	Disabled[2]
		Percent	
1967-1970	1.7	1.7	—
1971-1975	4.0	2.2	[3]4.6
1976-1980	2.7	2.3	6.6
1981-1985	1.8	2.0	-0.2
1986-1990	2.0	1.9	2.2
1991-1995	1.9	1.4	6.2
1996-2000	1.2	0.7	4.4

[1] Medicare beneficiaries are defined as the average number of persons with Hospital Insurance and/or Supplementary Medical Insurance eligibility during the calendar year. Growth rate for 2000 is preliminary.

[2] Includes persons eligible because of end stage renal disease.

[3] Represents average annual growth from 1973 (the first year of disabled eligibility) to 1975.

SOURCE: Health Care Financing Adminisitration, Office of the Actuary, 2000.

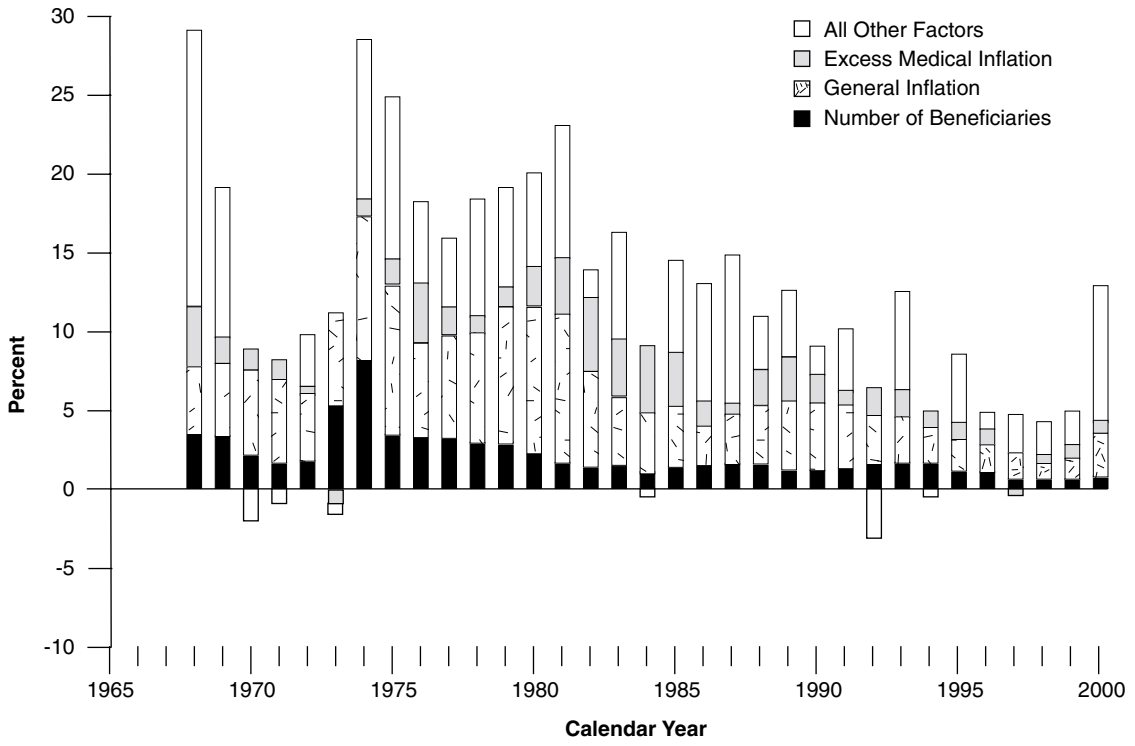
Medicare expenditure growth. Ideally, separate price indexes would be calculated for HI and SMI and would reflect the actual Medicare payment updates for each category of service (inpatient hospital, physician, and so forth). Unfortunately, creation of Medicare-specific price indexes poses daunting technical challenges, especially for SMI. In the absence of such indexes, the industrywide inflation factors shown in Figure 3 should be considered illustrative.

In practice, actual Medicare price increases have frequently been set below the prevailing level of medical inflation. For example, payment updates for inpatient hospital care are based on the inpatient hospital input price index or market basket, but Congress has reduced the update below the market basket increase in many of the years since the prospective payment system (PPS) was enacted. The intent is to provide a strong financial incentive for health care providers to maximize efficiency in the provision of care. As another example, increases in the Medicare fee schedule for physicians are currently based on changes in physicians' input costs (such as staff wages, practice expenses, and materials costs), but a penalty or bonus is added based on whether aggregate expenditures for physician services are above or below specified target levels. Thus, the prices paid by Medicare for medical services are not always closely associated with health providers' underlying input costs or the prevailing price changes in the health sector, as used in Figure 3.

The final growth category shown in Figure 3 for HI expenditures is labeled "all other factors" and represents the difference between total growth and the annual increases in the number of beneficiaries, general inflation, and excess medical inflation. This residual growth factor thus reflects changes in utilization and intensity of covered services as well as changes in Medicare reimbursement rates that differ from total medical inflation. As indicated, the "all other factors" growth category has been quite volatile. Its variation is related in large part to legislative changes, most notably the introduction of the PPS for inpatient services in October 1983 and the sweeping changes mandated by the BBA. Judicially mandated regulatory changes implemented in the late 1980s for skilled nursing care and home health care also contributed substantially to residual cost growth through 1997. Recent efforts to curb fraud and abuse appear to have contributed significantly to lower growth, first in the home health category and more recently with inpatient hospital costs (Savord, 1998).

Figure 4

Annual Increase in Supplementary Medical Insurance Expenditures, by Source of Growth: 1968-2000



NOTES: Growth rates for 2000 are preliminary estimates. Refer to text for definitions and limitations of price measures.
SOURCE: Health Care Financing Administration, Office of the Actuary, 2000.

The growth factors for SMI expenditures have shown a generally analogous pattern, as indicated in Figure 4. The number of beneficiaries has increased very similarly for both HI and SMI, and the same general and excess medical inflation factors are used here for both. SMI residual growth has been significantly larger than for HI in most years (4.5 percent versus 2.7 percent on average from 1967 to 2000), although the pattern of variation through time is similar. Key exceptions occurred with the introduction of the inpatient hospital PPS in 1984 and the introduction of physician payment reform in 1992. During each period, the respective program residual growth factors declined substantially. Following the BBA, HI residual growth declined, and SMI residuals increased somewhat, as a result of the transfer of a majority of home health services to SMI (Foster, 1998).

The fact that SMI expenditures have grown at a significantly faster pace than HI expenditures, on average, is attributable to a number of factors. First, many procedures, such as cataract removal, can now be performed in an outpatient setting (covered by SMI) rather than inpatient (covered by HI). Second, the legislation governing Medicare payments has arguably been tougher on institutional providers (largely HI-covered) than on physicians (covered under SMI). During much of Medicare's history, for example, hospitals were reimbursed for their "reasonable costs," while physicians received their "customary or prevailing charges." Since

1984, the inpatient hospital PPS, as already noted, has frequently limited payment updates below medical inflation. Most recently, as part of the BBA, Congress shifted roughly two-thirds of home health care costs from HI to SMI, in an effort to help delay the depletion of the HI Trust Fund. In fact, one could reasonably suppose that, in general, lower HI cost increases have historically reflected congressional efforts to forestall HI asset exhaustion, whereas less pressure has been brought to bear on SMI costs because they are automatically financed (as described further in the following section).

Overall, this review of Medicare expenditure trends shows a pattern of relatively rapid growth in most years, with occasional periods of slower growth attributable to important legislative or administrative initiatives. The recent elimination of most remaining cost-based reimbursement provisions by the BBA should contribute to more restrained growth in the future. Growth in the number of beneficiaries will accelerate, of course, with the retirement of the post-World War II baby-boom generation starting in about 2010. Also, the public will continue to demand—and likely receive—the benefits of new medical technologies as they are developed. Under present rules, further increases in the number of beneficiaries in Medicare+Choice managed care plans will have little impact on cost increases, because payment updates for such plans are based largely on increases in national Medicare fee-for-service costs. Thus, future Medicare expenditure growth, while less rapid than in the past, is still likely to continue to outpace the growth in workers' wages, self-employment income, and Federal general revenues for many years.

Review of Medicare Financial Status

From the very beginning of the Medicare program, Congress has required an annual assessment of the actuarial status of the HI and SMI Trust Funds. This requirement is based on the recognition that Medicare makes important financial commitments to current and future beneficiaries and that the government has an obligation to ensure that these commitments can reasonably be met in practice. The annual reports of the Medicare Boards of Trustees to Congress include detailed short- and long-range projections of the trust funds' future financial operations, together with an assessment of each trust fund's financial status (Board of Trustees of the Federal Hospital Insurance Trust Fund, 2000; Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, 2000). (Technically, there are two separate boards—one for the HI Trust Fund and another for the SMI fund. In practice, the memberships of the boards have always been identical to each other and to the Board of Trustees for the OASDI trust funds.)

The trustees note that the purpose of these projections is not to predict the future with certainty, which is obviously impossible, but rather to illustrate how the Medicare program would operate under specified reasonable economic, demographic, and health cost trends. Projections are shown under three alternative sets of assumptions to illustrate the uncertainty inherent in the estimates and to provide a test of sensitivity to the various assumptions.

In recent years, a few individuals have criticized the long-range Medicare projections, stating that estimates beyond 10 or 25 years are too uncertain to be useful. I

would argue, however, that this view undervalues the role of long-range projections and that it would be inappropriate not to make such projections. The HI program, for example, routinely makes financial commitments that can easily span the next 75 years. Young persons starting employment today at age 20 are assured that, in exchange for their HI payroll taxes now, they will qualify for HI benefits at age 65—some 45 years from now. Moreover, many of these individuals will live for as long as another 30 years or more thereafter. Accordingly, we should make every effort to ensure that the promises made today can actually be fulfilled in the future. To do otherwise could easily lead to overcommitment, future cutbacks in promised coverage, and (further) public distrust of government. I believe it is to Congress' credit, and that of every Administration since Medicare was enacted, that they have recognized and taken seriously the need to evaluate the long-range financial status of the program.

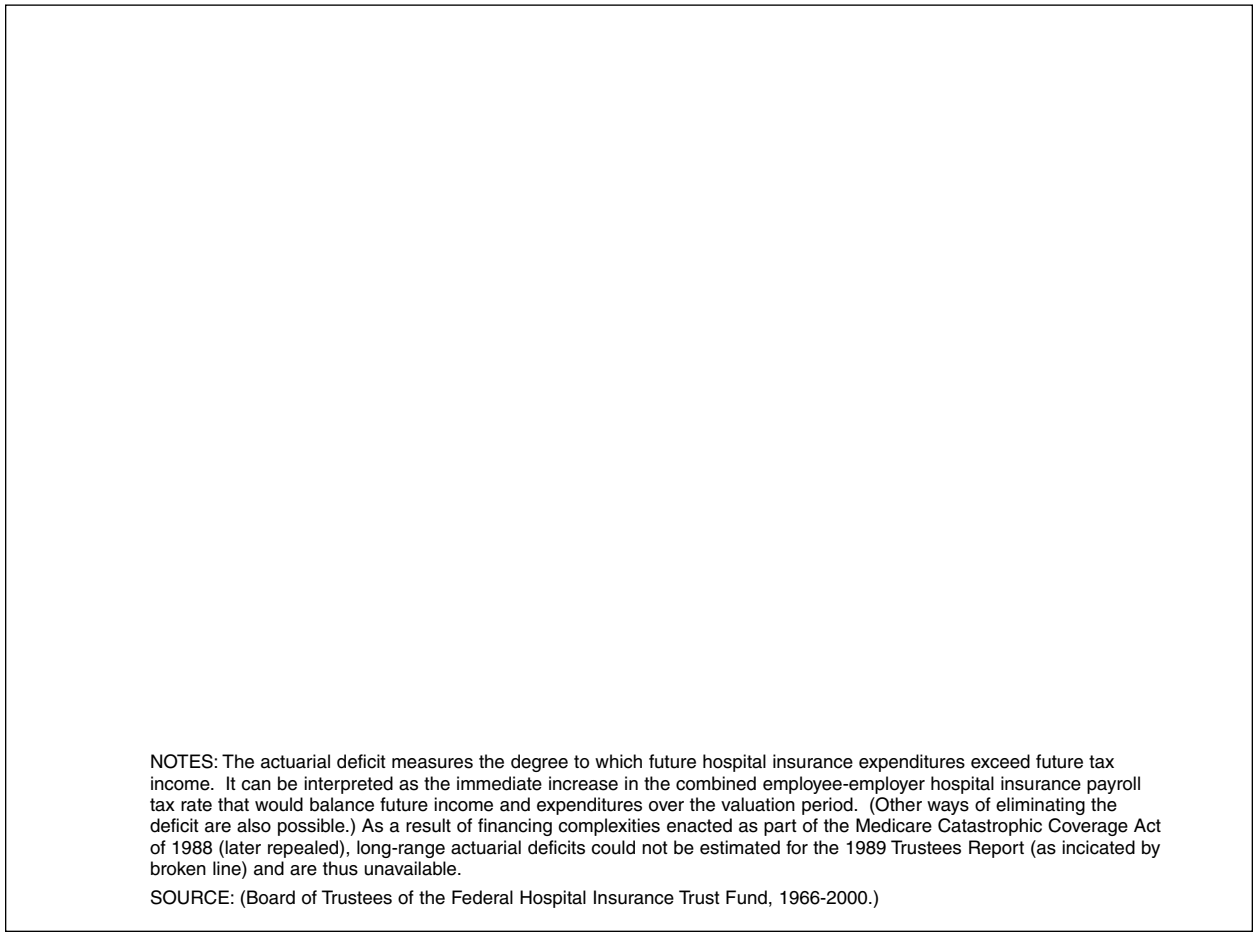
Without doubt, the long-range projections are sensitive to assumed future economic, demographic, and medical cost trends. However, we have an excellent idea of how many beneficiaries there will be for the next 65 years, because these individuals have already been born, and life expectancy tends not to change dramatically over time. We also have a fairly good idea about how the use of health care changes by age. Health expenditure growth can be volatile, as evidenced by the preceding discussion in this article. By relating costs to the underlying source of program income, such as taxable payroll or gross domestic product, we can obtain useful relative measures that minimize the volatile effects of future inflation. Finally, when the projections point to a serious long-range financial imbalance under a very wide range of reasonable assumptions, as is the case in the 2000 HI Trustees Report, then I believe it is sound public policy to address the imbalance and inappropriate to ignore it on the grounds that projections are inherently uncertain.

By way of comparison, long-range projections are routinely made for private pension plans. As actual wage increases, investment returns, mortality and disability rates, employee withdrawals, and other factors diverge over time from the actuarial assumptions, frequent small adjustments are made to the plan contributions to restore financial balance in the long range—and to prevent the need for potentially wrenching, last-minute changes. This model was also followed (albeit a little more loosely) for the Social Security program through the early 1980s.

The criticism of long-range projections may be based in part on the sensitivity of asset projections for the HI Trust Fund. The estimated year of depletion for HI has varied substantially throughout Medicare's history, most often attributable to new legislation affecting the program's financial status but sometimes following revisions in economic or other assumptions. In the short range, the estimated year of depletion is an important indicator of a trust fund's status. Over longer periods, however, it can change substantially as a result of even modest changes in assumptions. The change in assets during a year represents the difference between two very large amounts: total income and total expenditures for the year. In any such circumstance, as analysts have cautioned for centuries, the difference will be very sensitive to relatively small changes in either or both of the large numbers giving rise to the difference. Studies have indicated that the long-range "actuarial deficit" used by the trustees is a considerably more stable (and informative) measure of trust fund financial status than the year of depletion (Foster, 1989). Accordingly, the actuarial deficit is

Figure 5

Projected Long-Range Actuarial Deficits for Hospital Insurance Trust Fund: 1966-2000



NOTES: The actuarial deficit measures the degree to which future hospital insurance expenditures exceed future tax income. It can be interpreted as the immediate increase in the combined employee-employer hospital insurance payroll tax rate that would balance future income and expenditures over the valuation period. (Other ways of eliminating the deficit are also possible.) As a result of financing complexities enacted as part of the Medicare Catastrophic Coverage Act of 1988 (later repealed), long-range actuarial deficits could not be estimated for the 1989 Trustees Report (as incicated by broken line) and are thus unavailable.

SOURCE: (Board of Trustees of the Federal Hospital Insurance Trust Fund, 1966-2000.)

used in this article to summarize changes in the financial outlook for the HI Trust Fund over time.

Figure 5 summarizes the estimated long-range actuarial deficit for the HI program as it was presented in each of the Trustees Reports for 1966 through 2000. The deficit represents the amount by which projected HI tax income falls short of projected expenditures, on average, over the next 25 or 75 years.[3] Prior to 1984, HI projections were shown only for the next 25 years. Beginning in 1984, the Board of Trustees adopted the practice of showing full 75-year projections to recognize the financial implications of the baby boom's retirement and to match the longstanding practice for the Social Security program.

As indicated in Figure 5, the HI Trust Fund was initially estimated to be in actuarial balance in the 1966 through 1968 Trustees Reports. As utilization and medical price growth rapidly exceeded assumed rates, however, the 25-year deficit rose to about 0.75 percent of taxable payroll, despite amendments to increase HI payroll taxes.[4] The deficit was brought back to approximately zero by the Social Security Amendments of 1972, which

[3] The HI Trust Fund receives earmarked tax income from Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA) payroll taxes, and (since 1994) from a portion of the Federal income taxes paid on Social Security (OASDI) benefits. Interest income is accounted for implicitly through a present value calculation. Trust fund assets at the beginning of the projection are reflected in the actuarial deficit, as is a requirement for a fund at the end of the projection equal to 100 percent of annual expenditures. Refer to the 2000 HI Trustees Report for details (Board of Trustees of the Federal Hospital Insurance Trust Fund, 2000).

raised the HI payroll tax rate significantly and indexed the amount of earnings subject to the tax for future years.

Soon after, the projected actuarial deficit rose again, as the rapid inflation and other factors described previously contributed to benefit growth that substantially exceeded the increases in workers' wages and salaries. This unfavorable situation was compounded by the economic recession of 1974-1975. The actuarial deficit stabilized temporarily during 1978-1980, primarily as a result of the significant increases in the maximum wage base for HI taxes enacted by the Social Security Amendments of 1977 and the recovery from the prior economic recession. Before long, however, growth in HI taxable payroll was adversely affected by the recessions in 1980 and 1981-1982, and expenditures were driven by the highest rates of inflation experienced since World War II.

The financial outlook improved considerably with the deceleration in inflation after 1982, together with the major legislative changes enacted as part of the Social Security Amendments of 1983. In addition to the inpatient hospital PPS, these changes included an increase in the HI payroll tax for self-employed workers, mandatory coverage of non-profit employees, and prevention of coverage termination by State and local government employees. (In addition, coverage of Federal Government employees was mandated by the Tax Equity and Fiscal Responsibility Act of 1982.) As the economy rebounded strongly and experience with the inpatient PPS developed, the projected 25-year HI deficit declined steadily until reaching about 0.50 percent of payroll in 1988. This improvement also reflected enactment of several provisions reducing PPS payment updates during this period and mandating coverage of newly hired State and local government employees.

As noted previously, the trustees introduced 75-year projections for HI in 1984. The projected deficits for the longer period were substantially greater than for the first 25 years, reflecting the financial impact of the baby boom's retirement. The trend in the estimated 75-year deficit, however, largely matched that for the 25-year estimates.

The Medicare Catastrophic Coverage Act of 1988 established extremely complex financing provisions, including a supplemental beneficiary premium in the form of an income tax surcharge. As a result of these complexities, it was not possible to prepare long-range financial estimates for HI for the 1989 Trustees Report. The Catastrophic Coverage Act was subsequently repealed, in large part because of beneficiary displeasure with these same financing provisions.

Projected deficits began rising once again in the early 1990s as expenditures for skilled nursing facilities, home health care, and hospice services increased by as much as 40 to 50 percent annually. Simultaneously, the average complexity of inpatient hospital admissions increased faster than anticipated, and the economic recession of 1990-1991 reduced growth in payroll tax income. Legislation in 1990 raised the HI maximum wage base to $125,000 (substantially above the level imposed for OASDI, for the first time), but this change was not sufficient to offset the other factors that were adversely affecting the projected actuarial deficit. The 25-year deficit during 1993-1997 climbed as high as 2.10 percent of payroll, approximately matching the highest level previously projected (in the 1982 Trustees Report). The

[4] Long-range social insurance projections are usually shown relative to the primary source of funding for the program. Because the HI program is financed by taxes on wages, salaries, and net earnings from self-employment, costs are shown relative to the total amount of such earnings. This practice provides a more stable basis for long-range projections and avoids the extreme sensitivity associated with projections in nominal dollar amounts.

corresponding 75-year deficits were more than 4 percent of payroll. If such levels had continued, HI payroll tax rates would have to have doubled or expenditures been cut in half (or some combination) to close the deficit.

This dire financial situation was addressed in a number of ways. First, the Omnibus Budget Reconciliation Act of 1993 significantly increased financing by eliminating the maximum wage base for HI, so that the HI payroll tax applied to all earnings without limit. The same act increased the amount of Social Security benefits subject to Federal income taxes and allocated the additional revenue to the HI Trust Fund. Payment updates to hospitals, skilled nursing facilities, and home health agencies were also trimmed. At about the same time, a combined initiative by the Health Care Financing Administration, the Office of Inspector General in the U.S. Department of Health and Human Services, and the Department of Justice sought to reduce fraud and abuse in the Medicare program—particularly in the provision of home health services. These efforts had a major impact. Growth in home health expenditures, for example, declined from an average annual rate of 37 percent in 1990-1995 to 8.5 percent in 1996 and to -2.3 percent in 1997. The financial outlook began to improve further as a result of the reduction in inflation from previous levels, together with strong growth in payroll tax revenues associated with the surging economy starting in about 1997.

Even with the beginning of these favorable developments, the financial outlook for HI was still poor. This situation, together with the desire to reduce overall Federal budget deficits, led to enactment of the BBA. This sweeping legislation reduced payment updates for virtually all health care providers in 1998-2002 and replaced the remaining cost-based Medicare reimbursement mechanisms with prospective systems. The net effect of the BBA, combined with the simultaneous low inflation, rapid economic growth, and gains in combating fraud and abuse, resulted in the lowest projected 25- and 75-year actuarial deficits in more than two decades. In the 2000 Trustees Report, the 25-year deficit is a virtually insignificant 0.12 percent of payroll. For the longer range, however, the 1.21-percent deficit remains well outside the trustees' allowable margin, despite the substantial improvement relative to the 1997 and earlier projections.[5]

The financial status for the SMI Trust Fund is considerably easier to describe than that for HI. In short, beneficiary premiums and general revenue financing for SMI are revised annually to match the following year's estimated expenditures. A modest trust fund is maintained to cover differences between actual and estimated expenditures and to provide assets sufficient to meet any incurred-but-unpaid claims that would be left outstanding in the unlikely event that the program terminated. Thus, the SMI program is "automatically" in financial balance under present law over any future period. The official evaluation of actuarial status focuses on the relatively narrow issue of whether current assets are sufficient to meet outstanding claims and to provide a sufficient contingency reserve.

The Board of Trustees emphasizes that, despite the program's inherent financial balance, the rate of growth in SMI expenditures remains a serious concern. SMI costs have grown faster than those for HI in most past years, with the differential averaging

[5] Based on the 75-year projections, the trustees perform a specific test of long-range close actuarial balance. In view of the uncertainty inherent in such projections, projected future income may fall as much as 5-percent short of projected expenditures and still meet the requirements of the test. In the 2000 HI Trustees Report, the projected actuarial deficit represented more than 25 percent of future costs, substantially outside the allowable margin. Therefore, the HI Trust Fund does not meet the trustees= long-range test.

2.0 percent per year from 1967 through (estimated) 2000. The rapid increase in expenditures places a growing burden on beneficiaries, who finance approximately one-quarter of SMI through monthly premiums, and on Federal general revenues, where SMI has represented a steadily increasing share of the Federal budget.

CONCLUSION

Medicare has served the Nation well during its long history, despite the program's somewhat unusual coverage, eligibility, benefit, and financing provisions. The program's many benefits, however, have come at a cost that has grown quite rapidly more often than not. It seems unlikely that the Nation would be able to support such growth indefinitely, especially as the baby-boom generation reaches retirement age and becomes eligible for Medicare. The new payment systems established by the BBA will add to the pressures on the health care industry to provide care in a cost-efficient manner, especially compared with the prior cost-based reimbursement systems. Even so, technological advances and demographic changes will likely continue to drive costs at a faster rate than the taxable payroll or gross domestic product that underlie Medicare financing.

Therefore, our collective challenge will continue to be how best to balance the Nation's needs for high-quality and comprehensive health care with a cost that the Nation can afford. In the process of deliberating and deciding these issues, I would argue that greater attention should be placed on establishing long-range financial balance for Medicare. Although the HI program has been out of balance far more often than it has been in and has operated fairly successfully despite the prospective financial imbalance, there are significant consequences. First, delay in addressing deficits can lead to rushed action and inadequate time for consideration of how to address the problem most effectively. Working in crisis conditions does accomplish change but is not usually conducive to the most thoughtful or optimal solutions.

In addition, a change that is developed well in advance of a critical financial situation can be implemented more gradually, allowing us to avoid a sudden and drastic shift at the last minute with little warning. Even the range of possible solutions is greater when considered early. At the last minute, many potentially useful changes may not be feasible.

Finally, we risk doing a great disservice to program participants if we hold out the promise of Medicare benefits with specified eligibility, coinsurance, and tax requirements when, in fact, the promises cannot be realistically fulfilled without significant changes in one or more of these provisions. When the need for change is apparent, changes should be implemented with as much advance notice as possible, thereby allowing beneficiaries, workers, and health care providers an opportunity to adjust their expectations and plans. Public confidence in government and government programs is enhanced by their efficient operation and freedom from crises—especially those foreseeable many years in advance.

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DID THE BALANCED BUDGET ACT OF 1997 DO TOO MUCH?

It is often alleged that the BBA has had a far greater impact on Medicare payments to health care providers than Congress intended or anticipated. Is this accurate?

This question is not easy to answer. It is straightforward to know Medicare expenditures under the BBA, but no one can determine exactly what payments would have been without this legislation. For example, in the absence of the skilled nursing facility prospective payment system, effective July 1, 1998, what increases in the average cost per day would have occurred? And would the number of days of care have been the same? The best that can be done is to estimate these factors, but we would not expect an updated estimate of the BBA's financial impact—with one notable exception—to be substantially different from our original estimates in August 1997.

One can argue, fairly persuasively, that in many instances the actual impact of the BBA was exactly what Congress intended. For example, the legislation specified that Medicare payment rates for inpatient hospital admissions in 1998 would be frozen at their 1997 level—and this is precisely what occurred. Similarly, the payment update limitations mandated for other health providers were all implemented as specified. The actual savings from these provisions would be somewhat lower than originally estimated, because subsequent low inflation rates have reduced the "base level" against which these reductions apply. But again, we believe the overall impact would not be very far off from our original estimates.

It is certainly true that Medicare expenditure levels were significantly lower in 1998-2000 than we originally estimated at the time the BBA was enacted. To a great degree, however, this reduction is attributable to lower inflation rates and more success at addressing fraud and abuse than we had anticipated. Inflation, for example, averaged only about 2 percent in 1998-2000, rather than the 3.3 percent that was assumed at the time the BBA was enacted. The lower inflation carried through to many of the price indexes used to adjust Medicare reimbursement amounts, with the result that actual expenditures were significantly lower than previously estimated (roughly $6 to $7 billion in 2000), for reasons not associated with the BBA.

As another example, the inpatient hospital case-mix index decreased by 0.5 percent in 1998 and again in 1999, the first time this index had ever declined in the 16-year history of the inpatient prospective payment system. Analysis suggests that the decline is primarily attributable to changes in the coding of certain hospital admissions, particularly shifts in coding from "respiratory infection" to "simple pneumonia," and from cases "with complications" to those "without complications" (Savord, 1998). Not coincidentally, these coding categories were the focus of a recent investigation by the U.S. Department of Justice. These behavioral changes had a very substantial impact on Medicare expenditures in 1998-1999 (roughly $3 billion in 1999) and had nothing to do with the BBA.

There is one clear area in which the impact of the BBA was, in fact, dramatically greater than anticipated. The number of home health care visits in 1999 was less than one-half of the level in 1997. Although a significant decline was expected—and appropriate in view of the excessive and often fraudulent billing for these services in recent years—this change is still dramatic. The reasons for the abrupt fall-off in services are not yet fully evident. The continuing program integrity efforts certainly have had an impact, and available evidence

suggests that many home health agencies have misinterpreted the requirements of the BBA or are purposely erring on the conservative side to avoid the possibility of large retroactive settlements to Medicare. Even with these considerations, however, it is likely that the interim payment system has resulted in much of the abrupt decline in services and that this impact is significantly greater than Congress intended.

In view of the uncertainty associated with the factors underlying the slow growth in Medicare costs during 1998-2000, Congress and the Administration have focused on beneficiary access to care as an important indicator of whether reimbursement levels are too low following the BBA. This approach led to a number of targeted adjustments in the Balanced Budget Refinement Act of 1999, with a modest increase in Medicare expenditures in 2000 and later.

Why Medicare Part A and Part B, as Well as Medicaid?

Robert J. Myers

In the years before the Medicare and Medicaid programs were enacted in 1965, various groups had strong ideas about their possible structures. At one extreme were those who believed that Medicare should be a social insurance program covering all health care for the persons covered, on a compulsory basis, financed by payroll taxes, with a public assistance program as a safety net. At the other extreme were those who supported having only a public assistance program. Also involved in the debate was the American Medical Association (AMA), which opposed any program, whether social insurance or public assistance, if the plan were compulsory, on the grounds that this would eventually lead to socialized medicine.

The final legislative process was a matter of political compromise and was not by any means dictated by actuarial principles. Those who believed in the full-social-insurance approach generally supported a plan called the King-Anderson Bill. They attempted to gain the support of other groups by limiting their proposal in various ways. For example, it was proposed that physician services (other than those provided by hospital staff) be covered only for inpatient surgery. Also, coverage would, as a compromise, be limited to persons age 65 or over. At no time was it provided that out-of-hospital prescription drugs would be covered, primarily because, at that time, such costs were quite low and were seldom covered by private health insurance. This restricted version of compulsory social insurance became the foundation for what is now Part A of Medicare.

Proponents of the public-assistance-only approach, realizing that they could not defeat a social insurance plan, supported, as a counterproposal, the Byrnes Bill, a compromise program that would cover all physician and other services but on a voluntary basis (to accommodate the strong views of the AMA), financed partly by the enrollees, with the remainder of the cost coming from general revenues. And so was born the foundation for Medicare Part B, whose benefit and financing provisions were similar to those of the Byrnes Bill, except that the hospital and related benefits were carved out (because they would be covered in Part A).

Meanwhile, the AMA had sponsored a third proposal, popularly known as Eldercare, that essentially would have expanded the existing Federal-State Medical Assistance for the Aged Program and would have provided subsidized private health insurance for low-income persons and a partial-payment plan for others. This proposal became the basis for Medicaid.

The three separate health-benefits approaches were viewed by the various groups as competing proposals. In order to get a broad base of support in the House of Representatives, however, Ways and Means Committee Chairman Wilbur D. Mills proposed a new bill that would, insofar as possible, incorporate the essential features of all three of the major pending proposals—the King-Anderson Bill, the

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Byrnes Bill, and Eldercare. This politically logical approach took virtually everybody by surprise, including the sponsors of the three approaches. Mills' consolidated proposal eventually prevailed, thus resulting in today's Part A, Part B, and Medicaid, complete with the well-known disparities in coverage, benefit, and financing provisions.

In summary, those who favored a complete-social-insurance approach for the provision of all types of health care services for persons age 65 or over (along with a public assistance program as a safety net) received, in essence, all that they wanted. Part A provided for inpatient hospital services, Part B provided virtually total coverage for physician services—because the vast majority of persons who could be covered elected to do so—and Medicaid served as the safety net. Thus, the Medicare and Medicaid programs were not systematically designed and enacted but were instead the direct result of long years of evolution, debate, and political compromise.

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Medicare's End Stage Renal Disease Program

Paul W. Eggers, Ph.D.

Perhaps no other Federal Government program can lay claim to have saved as many lives as the Medicare end stage renal disease (ESRD) program. Since its inception in 1973, as a result of the Social Security Amendments of 1972 (Public Law 92-603, section 299I), over 1 million persons have received life-saving renal replacement therapy under this program. Prior to the enactment of this legislation, treatment was limited to a very few patients due to its extremely high cost and the limited number of dialysis machines. In the 1960s, it was not uncommon for hospitals that had dialysis machines to appoint special committees to review applicants for dialysis and decide who should receive treatment, the others were left to die of renal failure. Public Law 92-603 removed this odious task from the nephrology community. A person with ESRD is entitled to Medicare if he/she is fully or currently insured for benefits under Social Security, or is a spouse or dependent of an insured person. Consequently, entitlement is less than universal, with 92 percent of all persons with ESRD qualifying for Medicare coverage.

TREATMENTS

There are two basic treatments available to persons with ESRD—dialysis and transplantation. The most common form of dialysis is hemodialysis—the circulation of the body's blood through a machine that cleans the blood of toxins. The first artificial kidney machine was developed in the early 1940s in Holland. These machines could not maintain life for long because repeated treatments were not possible due to the lack of a means of repeatedly gaining access to the blood stream. The problem was partially solved in 1960, when a subcutaneous cannulae-and-shunt apparatus was developed that permitted the repeated access of patients to hemodialysis. Currently, the standard practice of hemodialysis are treatments 3 times a week for 3 to 4 hours at a time.[1] Although hemodialysis can be performed at home, the great majority of patients dialyze at one of nearly 4,000 facilities providing this service.

Another form of dialysis, done primarily at home, is peritoneal dialysis, of which there are three types. Continuous ambulatory peritoneal dialysis (CAPD) is the most common type of peritoneal dialysis. It needs no machine. With CAPD, the blood is continuously being cleaned. A solution called the dialysate, passes from a plastic bag through a catheter into the abdomen. The dialysate stays in the abdomen with the catheter sealed. After several hours, the person using CAPD drains the solution back into a disposable bag. Then the person refills the abdomen with fresh solution through the same catheter, to begin the cleaning process again. Continuous cyclic peritoneal dialysis (CCPD) is a form of peritoneal dialysis that uses a machine. This machine automatically fills and drains the dialysate from the abdomen. A typical CCPD schedule involves three to five exchanges during the night while the per-

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[1] Currently, a number of dialysis providers are experimenting with more frequent dialysis (5 or 6 timres per week, but of shorter duration, $1^1/_2$ hours.

son sleeps. During the day, the person using CCPD performs one exchange that lasts the entire day. Nocturnal intermittent peritoneal dialysis (NIPD) is a machine-aided form of peritoneal dialysis. NIPD differs from CCPD in that six or more exchanges take place during the night, and the NIPD patient does not perform an exchange during the day. As of 1998, 89 percent of patients used hemodialysis, 6 percent used CAPD, and 5 percent used either CCPD or NIPD (Health Care Financing Administration, 1999a).

Transplantation dates back to 1956, when the first successful transplant was performed on identical twins. Successful transplants of kidneys from cadavers began in the early 1960s. A successful transplant relieves the patient of the necessity of dialysis and usually improves the quality of life. However, the patient must take immunosuppressive drugs for the rest of his/her life to prevent the body's immune system from rejecting the transplanted kidney. At the time of the initiation of the program in 1973, transplantation was considered to be a bridge therapy between periods of dialysis (Kasiske et al., 2000) because of high graft failure rates. However, due to greatly improved graft success rates, transplantation is generally considered to be the optimal therapy for most patients.

LEGISLATIVE CHANGES

Although the basic entitlement provisions of the 1972 legislation remain in place, there have been a number of legislative changes to the program over the years. The first was the ESRD Program Amendment (Public Law 95-292) passed in 1978. The original legislation had limited Medicare entitlement to 1 year following a successful transplant. This was extended in 1978 to 3 years, although many successful transplant recipients remain on Medicare after this point because they qualify under the disabled or age provisions of Medicare. In addition, the 1978 provisions increased coverage of kidney acquisition costs and provided for more complete coverage of home dialysis costs. The Omnibus Budget Reconciliation Act (OBRA) of 1981 included the Medicare secondary payer (MSP) provision. MSP provides that, if a beneficiary has insurance other than Medicare, then the other insurer is responsible for medical costs prior to Medicare. OBRA 1981 set the MSP period at 12 months from the date of Medicare entitlement. Subsequently, it was raised to 18 months in 1990, and then 30 months in 1997. In addition, OBRA 1981 resulted in the development of the composite rate payment system for dialysis. Originally, dialysis was paid for on a cost basis with a upper screen limit of $138 per treatment. (The screen was $150 in the initial year, with $12 allowed for physician services.) This included an exceptions process which results in even higher payment levels, primarily to hospital-based facilities. Beginning in 1983, when the composite rate became effective, payment levels for hospital-based and freestanding facilities were roughly $131 and $127, respectively. These rates remained largely unchanged until the Balanced Budget Refinement Act of 1999, which increased the rates by 1.2 percent in both 2000 and 2001.

OBRA 1986 mandated the creation of a national registry for ESRD, which resulted in the United States Renal Data System (USRDS). The USRDS is a cooperative project between HCFA and the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDKD). NIDDKD provides most of the funding for the USRDS. HCFA provides extensive data from the ESRD Program Management and Medical Information System as well as fund-

ing for the economic studies portion of the USRDS. Since its first annual report in 1989, the USRDS has been the primary source of clinical, epidemiological, and economic information on ESRD in the United States.

The Balanced Budget Act of 1997 (Section 4558), mandated that HCFA develop a method to measure and report on the quality of renal dialysis services under Medicare. The development of quality of care measures did not take place in a vacuum. The renal community, including provider and patient groups (USRDS, NIDDKD, National Kidney Foundation, and HCFA) have a long history of working together on quality initiatives. For example, since 1993, HCFA has conducted an annual survey of quality measures (Health Care Financing Administration, 1999b). In 1997, the National Kidney Foundation published the Dialysis Outcomes Quality Initiative, a set of guidelines for adequacy of hemodialysis, adequacy of peritoneal dialysis, vascular access procedures, and treatment of anemia (National Kidney Foundation, 1997). Based on these previous efforts, HCFA has developed a set of 16 performance measures. It is anticipated that these measures, which will be applied at the individual dialysis facility level, will be published on the HCFA website (http://www.hcfa.gov) by late 2000.

TRENDS IN BENEFICIARY CHARACTERISTICS

As previously noted, prior to the enactment of the legislation creating the ESRD program, there were severe limits on the number of persons who received treatment. As a result, the ESRD patient profile prior to 1973 was much different than it became under Medicare. In 1967, the dialysis population was predominantly male (75 percent), overwhelmingly white persons (91 percent), and very young (7 percent over the age of 55). By 1978, there were equal proportions of males and females, black persons accounted for 35 percent of patients, and 46 percent of the dialysis population were over the age of 55 (Evans, Blagg, and Bryan, 1981). In addition to providing access to treatment more in line with the underlying renal disease burden, Medicare coverage greatly expanded the number of patients receiving treatment. Early estimates of the program were that as many as 10,000 new patients would initiate therapy each year and that the program would level out at about 35,000 beneficiaries (Klar, 1972). Program enrollment has far outstripped initial estimates. Program incidence (number of new patients each year) was over 14,000 in 1978, approximately 32,000 in 1986, approximately 65,000 in 1994, and reached 75,000 in 1998—over 7 times the initial estimates. The reasons for this increase are not well understood and are generally referred to under the designation of expanded acceptance criteria. Expanded acceptance treatment criteria are evident in two major areas—age and diabetes. In 1978 one-fourth of newly treated patients were 65 years or over. By 1998, well over one-half of new patients were 65 years or over at the time of renal failure. In the years before the Medicare ESRD program, diabetes was usually considered a contraindication to treatment. By 1978, persons whose renal failure was due to diabetes still accounted for only 10 percent of new patients. In 1998, 45 percent of new patients had renal failure due to diabetes. This expansion has occurred without specific design or intent. It appears that, as nephrologists and dialysis centers became more successful at treating these more fragile patients, referrals for treatment increased accordingly.

As previously noted, the two basic therapies are dialysis and transplantation. From the beginning of the program until the mid-1980s, there were rapid increases in both the number of transplants and in transplant success rates (Hariharan et al. 2000). As a result, the percent of patients with a functioning kidney transplant more than doubled, from 10 percent to 22 percent by 1986 (Eggers, 1988). Since 1986, growth in the number of transplants has slowed, largely because of the limitation in the number of donated cadaver kidneys. Much of the growth in the number of transplants in recent years is due to increasing numbers of living donor transplants. Living donors accounted for 20 percent of all kidney transplants in 1988 and 34 percent in 1998. Thus, despite the fact that transplant success rates are improving, the ever increasing dialysis population has offset these transplant gains. From 1986 to 1998, the percent of Medicare ESRD beneficiaries with a functioning graft has remained largely unchanged.

TRENDS IN PROGRAM EXPENDITURES

The original projections of annual program expenditures were quite low, having the program level out at about $250 million (Klar, 1972).[2] The program has grown far beyond these initial estimates. By 1979, it reached $1 billion, $5 billion by 1990, and, by 1998, had grown to over $12.3 billion. Despite this large increase in total expenditures, compared with the rest of the Medicare program, ESRD has been fairly successful at restraining per capita costs (Eggers, 2000). Enrollment increases account for much of the unexpected increase. Total ESRD Medicare enrollment in 1998 was almost 300,000, accounting for 0.8 percent of total Medicare enrollment, compared with 0.1 percent of Medicare enrollment in 1974. In addition, because expenditures increase with age and are greater for beneficiaries who are diabetic, the increasing percentage of patients who are elderly and/or diabetic has increased program expenditures by about 21 percent over the impact of enrollment increases alone.

In 1974, the average ESRD patient was 30 times as expensive as the average Medicare beneficiary. By 1998, the average ESRD patient was about 7.5 times as expensive as the average Medicare beneficiary. The reason for this is that during the 1970s and 1980s, when medical care inflation was usually in the double digits, two major parts of ESRD care, dialysis and physician care (known as the monthly capitation payment), remained largely unchanged. The dialysis payment rate (the composite rate), is lower in nominal terms in 1998 than it was in 1974. In inflation-adjusted terms, payment for dialysis is about one-third as great as it was in 1974.

TRENDS IN PROGRAM QUALITY OF CARE

Dialysis—The large decrease in inflation adjusted payment rates for dialysis has raised the question of how this has affected quality of care (Institute of Medicine, 1991, Health Care Financing Administration, 1989). There has been no evidence of decreased quality of care. Dialysis mortality rates have decreased in recent years (United States Renal Data System, 1999), from 28 percent in 1986 to 19 percent in 1996. In addition, the decreases in mortality have been greatest for persons with diabetes, among the most fragile of dialysis patients. Patient outcomes are improving in other areas as well. Healthy kidneys

[2] It is not clear whether the original estimates included Medicare expenditures not directly related to dialysis and transplantation. Costs for other covered Medicare services account for about one-half of expenditures on behalf of ESRD patients.

produce the chemical erythropoeitin, which stimulates the production of red blood cells. Thus, kidney failure often results in anemia as the body is unable to produce a sufficient supply of red blood cells. For a number of years, the only treatment of anemia was occasional blood transfusions. In 1989, the Food and Drug Administration approved the production of (and Medicare began payment for) a recombinant form of erythropoeitin. Now, virtually all hemodialysis patients, and many CAPD patients receive erythropoeitin. As a result, average hematocrit levels have increased. In 1993, only 46 percent of patients had a hematocrit above 30 percent. By 1998, this had increased to 83 percent (Health Care Financing Administration, 1999b).

Transplantation—The major problem in achieving a successful transplant is combating the body's natural immune system which attempts to reject the transplanted kidney graft. In the 1970s, the available drugs were somewhat limited. One-year graft survival rates for transplants from cadavers were about 50 percent. This success rate increased to about 70 percent in the 1980s. The introduction of cyclosporine in 1984 greatly increased the success of transplantation (Powe, Eggers, and Johnson, 1994), as has additional improvements in immunosuppression. As a result, by 1997, one-year graft survival rates had increased to 88 percent for cadaver grafts and 94 percent for recipients of living donor grafts. One-year patient survival rates are 94 percent and 98 percent for recipients of cadaver and living donor graft, respectively.

SUMMARY AND CONCLUSION

Medicare's ESRD program has largely achieved the original goal of providing access to life sustaining care for thousands of persons who would not otherwise have received care. During its 27-year history, many legislative changes have been made to refine coverage and entitlement issues. Despite certain limitations on payments, improvements in quality have been made, both for dialysis patients and transplant patients.

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Milestones in Medicare Managed Care

Carlos Zarabozo

Medicare managed care has a long history, dating back to the beginning of the Medicare program. The role and prominence of managed care in Medicare have both changed over the years; though plan participation has waxed and waned, enrollment has grown steadily. The greatest growth in Medicare managed care enrollment occurred in the middle to late 1990s, coinciding with the "managed care revolution." Enrollment growth has slowed in recent years, plan participation is declining, and the future of the program is not easy to predict.

INTRODUCTION

The President, in his message to Congress, decries the runaway inflation in health care costs, the inequities in access to health care, and the variation in the quality of health care across the Nation and across income classes. He champions a novel approach to national health care reform that would rely on market forces to bring discipline to the health care system. Congress balks and does not give the President what he wants, but in the years that follow, reform is achieved, after a fashion.

A familiar story? The President is, of course, Richard Nixon, conveying a message to Congress in 1971 and pointing out how much the Federal programs contributed to "this growing investment in health" as a portion of national expenditures (National Health Insurance Proposals, 1972). The novel approach he advocates is the "health maintenance strategy." Unlike a later President's proposal—which specifically excluded Medicare from the novel managed competition approach—the Nixon Administration's health maintenance strategy would have begun with the then-relatively-new public programs, Medicare and Medicaid. Having started with the Federal Government programs, "the government's actions would catalyze similar restructuring in the private, largely employer-financed segment of the health economy that also was having difficulty coping with medical inflation" (Ellwood and Lundberg, 1996).

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Medicare Managed Care in 1965

This historical tidbit illustrates the close ties that exist, or some hoped would exist, between Medicare and managed care. Although in 1965 the term "health maintenance organization" (HMO) had yet to be coined, what came to be known as HMOs, or their precursors (such as group practice prepayment plans), have been a part of the Medicare program since its inception in 1965. To be more precise, the Medicare program recognized prepaid health care plans as a different kind of entity for which a different kind of payment method was necessary. In 1965, prepaid plans were accommodated by permitting them to be paid on a reasonable cost basis for services (such as physician services) that the program would otherwise be paying on a reasonable charge basis.

This approach to payment made sense in that, if the HMO-like organization used salaried physicians, there would be no service-by-service billing by the physicians

and, therefore, no "charge" other than the aggregate "charge"—a salary—for any and all services rendered by the physician. In choosing between the two available payment options that Medicare used in 1965—reasonable charge payments and reasonable cost payments—this seemed like a suitable approach, but not necessarily a perfect fit. Thirty-five years later, we are still in search of a "perfect fit" in Medicare's approach to payment of HMOs.

1972 Amendments

The history of managed care and Medicare can be described through milestones that generally coincide with legislative history. After 1965, as previously alluded to, the next major milestone in Medicare HMO provisions was historic—in a symbolic sense if not in a practical sense. Although Congress may not have given the then-President everything he asked for, one result of the Nixon Administration's push towards health care reform was passage of the HMO Act of 1973. Before the HMO Act, however, the first Federal legislation in which the term HMO was defined was the Medicare provisions of the 1972 amendments to the Social Security Act.

The 1972 amendments introduced Medicare HMO enrollment and contracting, as opposed to merely providing for a mechanism to secure reimbursement for services rendered by such organizations. HMOs had to meet certain standards, had to provide the full range of available Medicare services, and had to have open enrollment for all Medicare beneficiaries in the service area. However, the new payment methodology eventually agreed upon for Medicare HMOs proved to be not very popular with HMOs. The original version of what became the 1972 amendments (H.R. 1 of 1971) included, for Medicare HMOs, a prepaid, capitated payment methodology that was more consistent with the usual method of prepayment (and quite similar, in fact, to the methodology of the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA]), described later, incorporating a requirement that excess revenues be used for extra benefits).[1] The bill that was passed had Medicare HMOs being paid on a "risk-sharing" basis, with a non-risk cost reimbursement contracting option also available. Group practices, union and employment-based plans, and HMOs could also continue to be paid under the pre-existing cost reimbursement method (and such organizations would not have to comply with the open enrollment requirements applicable to contracting HMOs).

Under a risk-sharing contract, interim payments would be made, and the costs incurred each year by a contracting HMO would be compared with the adjusted average per capita cost (AAPCC)—an estimate of program expenses that otherwise would have been incurred for the Medicare beneficiaries enrolled in the organization. If the organization achieved "savings" in relation to the AAPCC, up to 20 percent of the savings would be split equally between the Federal Government and the HMO. Savings in excess of 20 percent would go to the Federal Government. Losses were the responsibility of the HMO, but could be carried over into subsequent years and offset against savings. Very few HMOs took advantage of this option. In 1979, there were 32 group practice prepayment plans (the pre-existing cost reimbursement option), 32 HMO cost contractors, and only 1 risk-sharing HMO (Langwell and Hadley, 1989).

[1] Refer to the Social Security Amendments of 1972, H.R. 1 Report No. 92-1230, September 26, 1972, stricken language.

Demonstration Projects

Again, the perfect fit—the right payment methodology for Medicare HMO payments—had not been achieved. However, the 1972 amendments also introduced additional authority, beyond that introduced in 1967, for Medicare demonstration projects of such things as prospective payment methods and payment for comprehensive services. Continuing the quest for the perfect payment methodology, in 1980 the Medicare capitation demonstrations began, to be followed by the Medicare competition demonstrations and, eventually, the next legislative milestone, the TEFRA risk program.

TEFRA

Other than in demonstration projects, a contracting option for Medicare HMOs operating on a full risk basis would not be available until the changes made by TEFRA were to become effective, which, according to the legislation itself, would be 13 months after enactment or, if later, after "the Secretary…notifies…[Congress]… that the methodology to make appropriate adjustments…has been developed and can be implemented to assure actuarial equivalence in the estimation of the adjusted average per capita costs." The TEFRA risk contracting program authorized in 1982 would begin in mid-1985, after publication of the final regulations in January 1985.

Under TEFRA, contracting HMOs or competitive medical plans (which were essentially HMOs that did not have a Federal qualification designation under the HMO Act of 1973) would be paid 95 percent of the AAPCC on a full risk basis. The 5 percent differential recognized the presumed greater efficiency of HMOs and their ability to reduce program expenditures. Any additional savings, determined through a prospective comparison of projected costs with projected AAPCC payments, had to be (a) returned to beneficiaries in the form of extra benefits or reduced cost sharing; or (b) used to fund future additional benefits; or (c) be returned to the Federal Government. HMOs were allowed the normal level of profit, or retained earnings, that they customarily received in the private sector.

There were certain changes to the earlier law. What had been a requirement that no more than 50 percent of an organization's membership could be over the age of 65 became the new 50/50 rule, limiting Medicare and Medicaid enrollment to no more than 50 percent of total enrollment—a provision that could be waived by the Secretary of Health and Human Services. Although the open enrollment requirement was continued, Medicare beneficiaries (of any age) with end stage renal disease (ESRD) were prohibited from enrolling in TEFRA HMOs, unless they were already members of the HMO (as pre-existing Medicare enrollees, or as non-Medicare enrollees continuing in the HMO). The cost contracting option continued to be available to HMOs, and HMOs (and other organizations) could continue to be paid under the health care prepayment plan (group practice prepayment plan) option.

AAPCCs were computed for each county of the United States, with separate rates for the disabled and elderly (and statewide rates for ESRD enrollees), and certain adjustment factors were applied to better approximate fee-for-service (FFS) costs: age, sex, institutional status, and Medicaid status. However, there was no direct health status adjuster. As would become evident, the lack of a health status adjuster meant that there was still not a perfect fit in the payment methodology.

The TEFRA program enjoyed a certain level of success in its earliest years. In 1985 there were 480 operating HMOs in the

U.S. and 87 Medicare risk contractors. By the end of 1987, the number of risk contractors rose to 161 (out of 662 operating HMOs [Group Health Association of America, 1993])—the "high water mark" for the first 10 years of the program. Risk enrollment rose in every year, but not very dramatically, from 1.1 million at the end of 1985 to nearly 2 million by the end of 1990.

As measured by beneficiary interest in the program, Medicare managed care, in areas where it was offered and included additional benefits, was a highly successful program. In south Florida, for example, Medicare HMOs offered drug coverage and low out-of-pocket costs through "zero premium" plans (plans in which enrolled members did not have to pay an additional premium beyond the Medicare part B premium). The ability to provide additional benefits in certain areas was partly a function of the payment methodology, which recognized the extreme variation in Medicare FFS expenditures in different counties: some counties had per capita costs that were two to three times more than other counties. These payment differences were very visible to Medicare beneficiaries, with residents of Minnesota and Massachusetts, for example, less likely to have the kind of added benefits that were available in the Miami and Los Angeles areas.

Milestone of Another Sort

During the early TEFRA years, the largest Medicare contractor was International Medical Centers (IMC) of Florida, which began as a demonstration project and continued as a TEFRA contractor. It consisted almost exclusively Medicare enrollees, operating under the authority of a waiver of the 50/50 rule. The demise of IMC in 1986 was the low point in the history of Medicare managed care. The organization had enrolled over 100,000 Medicare beneficiaries. The following indicates the drama associated with this particular episode of Medicare managed care history. This is the text of the FBI international crime alert regarding the head of IMC:

> "In 1986, a federal government task force was established to investigate charges of corruption and fraud on the part of Miguel Recarey, Jr. Recarey was then head of International Medical Centers, America's largest health maintenance organization. During its peak years, International Medical Centers received three-hundred sixty million dollars a year in U.S.- government Medicare funds. In April 1987, the first indictment was returned in Miami, Florida, against Recarey and three co-defendants for conspiracy, bribery, obstruction of justice, and illegal wiretapping."

The IMC crisis for Medicare and for the Medicare enrollees of the organization was alleviated when Humana took over operation of the plan, which continues operating to this day. However, the image of Medicare HMOs was tarnished by the IMC experience for many years afterwards.

Fits and Starts in the Late 1980s

In the late 1980s and early 1990s, the number of Medicare-contracting HMOs began to decline (as did the number of operating HMOs in the U.S.). From the 1987 high of 161, the number of contracting plans declined to 93 by December 1991. In 1989, for example, Prudential Insurance, which had applied to have 30 contracts across the U.S., scaled back its Medicare contracting to only a few plans. Enrollment continued its rise, however, reaching 1.4 million beneficiaries in risk plans by the end of 1991, even though the number of contracts was at its post-1985 low point in 1991.

During this period, relatively large numbers of Medicare beneficiaries were affected by contract terminations or service area reductions (under a new policy of the mid-1980s which allowed HMOs to choose which counties they wanted to include in their Medicare contracts among those counties where they otherwise operated). For the years 1987-1989, terminations affected an average of nearly 7 percent of enrollees each year (not including those affected by service area reductions).

Not All Milestones Are Legislative

With the managed care revolution of the mid-1990s, HMOs burgeoned in the private sector as well as the public sector. Medicare HMO enrollment doubled between 1993 and 1996 (to 4.1 million enrollees), just as enrollment overall in HMOs doubled from January 1993 to a January 1999 level of 81 million (Interstudy, 1999). Between December 1994 and December 1998, Medicare risk HMO enrollment nearly tripled, rising to 6.1 million beneficiaries, or over 15 percent of the Medicare population. Within areas in which Medicare HMOs were available, one in five beneficiaries had elected to enroll in a plan, while in the private employer market, about one-third of individuals were covered by an HMO (Buckley and D'Amaro, 1998). While in 1993 only about one-half of Medicare beneficiaries resided in a county in which a risk plan was available, the interest in Medicare contracting expanded to such an extent that by 1998, 74 percent of beneficiaries had at least one Medicare plan available in their area.

Medicare+Choice

The most recent major legislative milestone was the Balanced Budget Act of 1997 (BBA). It was heralded as the most significant change in private plan contracting in the history of Medicare. The BBA introduced major revisions in the types of private plans that could have Medicare contracts, the contracting standards to be applied, beneficiary enrollment rules, and payment rules. The BBA also finally introduced a Part C of Medicare, "Medicare+Choice (M+C)," a quarter of a century after the Nixon Administration's proposal to add Part C. Under Part C, new types of organizations included provider-sponsored organizations, preferred provider organizations, medical savings account plans (on a demonstration basis), private FFS plans (the first "defined contribution" option, because there is no statutory limit on its Medicare premium), and religious fraternal benefit organizations.

Continuing to look for that perfect fit in the approach to payments, the BBA made a number of major changes in the method of computing Medicare capitation payments to health plans. The BBA introduced national/local blended rates, a payment floor for the lowest-paid counties, and a minimum update payment. Under the minimum update provision, all counties are guaranteed a payment increase of 2 percent over the preceding year's base rates. Annual payment increases after 1997 would be based on an update factor that is the rate of increase in projected Medicare expenditures each year, less a statutorily specified reduction (as opposed to the AAPCC methodology, under which each county's rate of increase would be based on a projection of the actual incurred Medicare expenditures in the county for the year in question).

In general, historically lower-paid counties (which are less likely to have had Medicare managed care plans) would receive higher payment increases as a result of the BBA's payment floor and the phased-in national/local blended payment

rate—attempting to address the Miami versus Minnesota issue of M+C benefits varying as a reflection of Medicare FFS payment rates. Many counties that historically had higher payment rates had their rate increases reduced by the BBA.

The BBA also reduced M+C capitation rates by phasing in the removal of direct and indirect medical education payments from M+C rates beginning in 1998, providing instead for phasing in direct payment of these "carved out" amounts to the hospitals providing care to M+C enrollees.

The BBA applies a budget neutrality adjustment to the blended rates. The effect of this adjustment in 1998 and 1999, as well as in 2001, was to have payments at the "floor" level or at the minimum 2 percent update level for all counties. For the year 2000, blended payments were made for the first time. (The BBA Refinement Act [BBRA] modified some of the payment provisions: the update factor reduction for 2002 is changed to 0.3 percent rather than 0.5 percent; and bonus payments for 2000 and 2001 are provided to the first organization entering an area that has not had a M+C plan since 1997.)

The BBA also requires that health status be used to adjust payments to M+C plans, in light of the evidence over the years of favorable selection in HMOs—i.e., enrollees tend to be healthier than average Medicare beneficiaries but plans are paid based on costs for an average population (U.S. General Accounting Office, 2000a). HCFA chose to introduce the BBA risk adjustment methodology on a phased-in schedule, and the BBRA modified the phase-in schedule to more gradually phase in the share of payments that would be computed on a risk-adjusted basis.

Some of the BBA changes appear, to date, to have been more symbolic than practical, to repeat a phrase used about the 1972 amendments. Only one provider-sponsored organization contracted with Medicare after the BBA, and that organization will terminate its contract at the end of 2000. One private FFS plan is operating, and there are preferred provider organization applications pending. The BBA's repeal of the 50/50 rule has not resulted in any HMOs going into new areas as Medicare-only HMOs, and the payment floor and blended rates (when possible under the budget neutrality rules) have not resulted in increased access in rural areas.

Terminations in 1998-2000

For the 2001 contract year, over 900,000 Medicare beneficiaries—about 15 percent of all enrollees—will be affected by a plan termination or service area reduction. About 150,000 will not have access to another M+C plan (other than the private FFS plan in some areas). Overall, only 63 percent of Medicare beneficiaries will have access to an M+C coordinated care plan in 2001. In the preceding year, 327,000 enrollees were affected by terminations and service area reductions (5 percent of enrollees), with 79,000 left without an M+C plan available. In the preceding year, at the end of 1998, 407,000 enrollees were affected. For the first time since the beginning of the program, overall enrollment declined from one year to the next (December 1999 to January 2000, from 6.35 million to 6.19 million).

These changes may give one pause as to whether the BBA did the opposite of what it was intended to do (in terms of expanding private health plan choices for beneficiaries while also controlling Medicare expenditures). However, just as one could note that the increase in Medicare enrollment that coincided with the managed care revolution cannot be traced to any particular change in Medicare, one might also argue that other factors besides the BBA changes explain the post-BBA downturn in

enrollment trends among Medicare beneficiaries and the leveling off of interest in Medicare on the part of HMOs and other private plans. The U.S. General Accounting Office, for example, argues as much (U.S. General Accounting Office, 1999; 2000).

Murky Future

What the future holds is difficult to say, other than perhaps to say that these things—the insurance cycle, actions by Congress to control Medicare expenditures—are cyclical (a redundancy in the case of the insurance cycle, except that some had claimed the insurance cycle had disappeared). It is probably wisest not to opine on this issue. Health policy analysts are notoriously bad at making predictions. When the HMO Act was enacted in 1973, the Nixon Administration announced a strategy calling for the development of 1,800 HMOs—a projection somewhat off the mark. To cite another example, in 1990, very few people would have predicted the managed care revolution, and the consequent pre-eminent role to be played by managed care plans and the virtual disappearance of FFS indemnity plans. Later, in the midst of the managed care revolution, perhaps few people would have thought that the future of managed care was not secure—its success at controlling costs would ensure that it would be the model for health care forever after, and its success in attracting Medicare beneficiaries would continue indefinitely.

Loose Ends

A different way to approach the question of predicting the future is merely to recite what the past has left undone. The perfect fit in payment has not been achieved (but may be forever elusive—would it be through some competitive pricing approach?). Extending managed care to rural areas remains problematic, and matching the needs of certain populations with managed care plans is an issue (e.g., those with ESRD, the disabled). Perhaps, with time, other viable models of managed care or private health plans will be developed for Medicare as a result of the BBA. Thirty-five years just seems not to have been enough time to sort all this out, but as the history shows, people are at least aware of some of the issues worth pondering in Medicare managed care.

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Evolution of Quality Review Programs for Medicare: Quality Assurance to Quality Improvement

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This article outlines the development, successes, and future directions of the Medicare Peer Review Organization (PRO) program. As established by the Tax Equity and Fiscal Responsibility Act of 1982, the purpose of the PRO program is to promote the quality, medical necessity, and appropriateness of services reimbursed through Medicare. We describe the evolution of the PRO program from a retrospective quality review approach, focused on individual events, to a proactive, quality improvement approach. Priorities for future development are described, including the identification of additional clinical areas for attention, improvements in program infrastructure, and broadening the scope of projects to new provider settings.

INTRODUCTION

Soon after the enactment of the Medicare program in 1965, it became clear that fulfilling the mandate of providing health care security to Medicare beneficiaries would require assurances that funds were used effectively and that beneficiaries received care consistent with medical quality standards. The systems designed and implemented to meet these obligations matched what was occurring throughout the health care industry. Here we discuss the evolution of these systems from quality assurance, primarily based on retrospective quality review, to proactive quality-improvement approaches, and describe the direction of the quality improvement program as administered by HCFA.

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DEVELOPMENT BEGINS

In 1971, Congress authorized the Experimental Medical Care Review Organizations (EMCROs) to determine whether area physician groups could reduce unnecessary utilization of services reimbursed through Medicare and Medicaid (Institute of Medicine, 1990). Reviewing inpatient and ambulatory services, the EMCROs focused on individual cases to improve the appropriateness and quality of care. The EMCRO program provided the model for the first legislated Medicare quality review program, the professional standards review organizations (PSROs).

The first national quality-assurance system administered as a part of Medicare itself, the PSRO program, was established in 1972 by amendment to Title XI of the Social Security Act. Based on the EMCRO model, the PSRO program reviewed services and items reimbursed through Medicare. The purpose of these reviews was to determine whether such services and items were medically necessary, had a quality that met professionally recognized standards, and were provided in the most effective, economic manner possible.

Through the PSRO program, a mechanism was implemented to monitor services, to ensure the quality of care provid-

ed to beneficiaries, and to ensure that appropriate action was taken when it appeared that Medicare beneficiaries had received care that did not meet recognized standards (Institute of Medicine, 1990). However, with their focus primarily on utilization review, PSROs were widely viewed as a mechanism for containing costs and controlling medical practice, not as a means of improving clinical quality of care.

The PSROs were also highly localized in their areas of coverage, with 195 separately designated PSRO areas by 1981 (Mihalski, 1984). The localized structure ensured that assessment of cases reflected local practice patterns. This fragmentation led to large differences in PSRO operations, including differences in funding mechanisms. Some PSROs were funded by grants, some operated by cooperative agreement, and some undertook formal contracts with the Federal Government. This loose program structure contributed significantly to wide variations in individual PSRO performance and made it virtually impossible to make comparisons between them. Despite extensive efforts, the PSRO program was unable to effectively contain increasing health care utilization and costs.

DEVELOPMENT CONTINUES

In the early 1980s, concern about the viability of the hospital insurance and supplementary medical insurance trust funds, about protection of beneficiaries, and about the quality of care reimbursed through Medicare increased. These concerns led to changes in the quality-assurance system and the reimbursement structure for Medicare.

To increase consistency and effectiveness of quality review organizations, Congress, through the Peer Review Improvement Act of 1982 (Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982) (Public Law 97-248) dismantled the PSRO structure, and in its place, authorized the utilization and quality control peer review organization (PRO) program. Section 1862 (g) of the Social Security Act required the Secretary to contract with utilization and quality control PROs to promote the economy, effectiveness, efficiency, and quality of services reimbursed through Medicare.

The Deficit Reduction Act of 1984 (Public Law 98-369) mandated development and implementation of the Medicare prospective payment system (PPS), designed to contain spiraling health care costs by reimbursing providers at a fixed rate based on diagnosis-related groups (DRGs) reflecting the groups and quantities of resources typically used per instance of a specific diagnosis, replacing a reimbursement system based on reasonable or prevailing charges. The financial incentive for providers subject to PPS is to reduce the resources expended per hospital stay either by reducing the kinds or amounts of services provided or by reducing patient length-of-stay. Thus, the advent of PPS further increased the importance of quality assurance and utilization control oversight of health care services provided to Medicare beneficiaries.

In 1984, HCFA issued a request for proposals to contract with PROs for utilization and quality control. The PSRO regions were consolidated into 54 regions consisting of each State, the District of Columbia, Puerto Rico, the Virgin Islands, and the combined area of Guam, American Samoa, and Northern Marianas (later merged with Hawaii, leaving the current 53 regions). PROs are physician-sponsored or physician-access organizations that are paid under contract by the Federal Government to review medical services reimbursed by the Medicare program. The PROs are the primary tool for monitoring the quality of

medical services provided to Medicare beneficiaries. PROs are contracted to ensure that the reviewed medical care is medically necessary, is provided in the most appropriate setting, and meets professionally recognized standards of care.

The first PRO contract cycle (1984-1986) retained a strong emphasis on reducing inappropriate admissions. PRO activities at that time continued to focus on retrospective case review with educational or punitive measures for individual providers when appropriate or necessary. Targeted and random samples of cases meeting specified parameters were selected from electronic hospital reimbursement claims from the PRO's area. PROs obtained and reviewed copies of the complete medical record for the selected cases. If the care did not meet professionally accepted standards or was not delivered in the appropriate setting, the PRO could use its authority to deny part or all of the payment to the provider. Consequently, the relationship between PROs and provider communities was frequently adversarial.

During the second (1986-1989) and third (1989-1993) contract periods, although there were modest changes in the PROs' activities, the retrospective review process continued. However, there was an evolving awareness within HCFA, the PROs, and the health care industry that retrospective individual case review was not an effective means of improving the overall quality of health care. Research had revealed that patterns and outcomes of care vary between regions and between specific hospitals in ways not explained by known variations in severity of patient illness (Chassin, Brook, and Park, 1986; Health Care Financing Administration, 1986). Other research indicated that physician review of hospital medical records had questionable reliability (Rubin et al., 1992). Fostering positive changes in physician behavior was further stymied by the very nature of retrospective case review, a process that emphasized the review of idiosyncratic, often unusual events that were discovered long after the examined event had occurred.

By the late 1980s, there was also a growing understanding that even care that met recognized standards could be improved through the use of quality improvement models. New models of quality improvement began to be seriously considered by the health care industry. These models focused on improving standards of care by improving care delivery processes, information systems, and training resources. The new models required analysis of patterns of care, and improvement projects aimed at improving specific processes of care.

During the third contract cycle (1989-1993), HCFA began shifting the PRO program's focus toward developing a collaborative relationship with the provider community to create a cooperative program for actively and prospectively improving health care. The residual effects of the older adversarial relationship between PROs and providers were a challenge at the launch of the Health Care Quality Improvement Initiative (HCQII).

Implemented in 1992, the HCQII marked a significant milestone in the evolution of the PRO program. The HCQII moved from concentrating on individual clinical errors to analyzing patterns of care and outcomes as the means toward monitoring and improving mainstream health care (Jencks and Wilensky, 1992).

Originally scheduled to end in 1992, the third PRO contract cycle was extended into 1993 to allow refinement of the fourth contract's design and requirements. HCQII and the new models of quality improvement emphasized the creation of quality-improvement projects. Clinical practice guidelines published by the Federal

Government and professional health care groups provided another resource for such quality-improvement projects. Analyses of patterns of excellence and error in clinical care were used to identify priorities for the design of condition-specific, process-improvement (care-improvement) projects

The first HCQII project was the Cooperative Cardiovascular Project (CCP). The CCP aimed to improve the care delivered to patients with acute myocardial infarction. Quality-of-care indicators were jointly developed by the American College of Cardiology, the American Heart Association, the American Medical Association, and HCFA (Jencks and Wilensky, 1992). The CCP was the first structured attempt by HCFA's PRO program to use process of care indicators to identify areas of quality or performance to target for potential improvement. The CCP demonstrated, based on pre- and post-intervention measures of the quality indicators, that implementing interventions aimed at assisting providers to change care processes can lead to increased rates of compliance with best-clinical-practices guidelines, and to improved outcomes (Marciniak et al., 1998; Marciniak, Mosedale, and Ellerbeck, 1998).

HCFA and the PRO program quickly learned that promoting continuous quality improvement is itself an evolving process. The HCQII underwent many changes as it evolved into the Health Care Quality Improvement Program (HCQIP) program as it is implemented in the current PRO contract (Chin, Ellerbeck, and Jenks, 1995; Weinmann, 1998). Retrospective case review was replaced as the primary PRO activity by quality-improvement projects. Since the quality improvement approach is data driven, the evolution of new data systems and methods of quality-indicator measurement were necessary (Fitzgerald, Molinari, and Bausell, 1998). HCFA decided to create two clinical data abstraction centers to increase the efficiency, consistency, and quality of clinical data abstracted from patient records. These abstracted data provide much of the raw material used to construct baseline and post-intervention estimates of the frequency with which indicated care processes are delivered.

During the fourth and fifth contract periods, PROs worked to create partnerships with HCFA, providers, experts, and citizens to identify and document opportunities to improve health care for Medicare beneficiaries. More than 2,000 cooperative projects between PROs, health care providers, and beneficiaries addressed quality of care, medical necessity, appropriateness of health care setting, readmissions, and DRG coding (Health Care Financing Administration, 1996). Although the PROs reported improvement in two-thirds of their projects, HCFA was not able to demonstrate any overall improvement or impact on quality (Health Care Financing Administration, 1998).

TODAY

Begun in 1999, the sixth (and current) PRO contract refined and expanded upon the accomplishments of the fourth and fifth contract cycles. The primary goal is to improve the care delivered to all Medicare beneficiaries by implementing statewide improvement projects using standardized quality indicators in specific clinical areas. The PROs are directed to build quality improvement projects in partnership with other government and private entities.

The current PRO contracts are divided into tasks. Task 1 directs the PROs to improve the care for six clinical topics that are major sources of mortality or morbidity for the Medicare population. There is strong scientific evidence and provider

consensus that improving performance on the 24 indicators for these topics will lead to improved outcomes (Jencks et. al, forthcoming). Task 2 directs the PROs to implement three types of local quality improvement projects. First, each PRO is required to conduct an improvement project aimed at reducing a disparity between the care received by a disadvantaged group of Medicare beneficiaries and all other Medicare beneficiaries in the State. Second, PROs must implement a project in a setting other than acute care hospitals. PROs are also encouraged to conduct projects on topics of local significance. Task 3 directs the PROs to partner with managed care organizations to ensure beneficiaries enrolled in such plans receive the same level of attention from the HCQIP as those covered by traditional fee-for-service Medicare. Task 4 directs the PROs to reduce payment errors for inpatient care. The Payment Error Prevention Program is designed to reduce the amount paid in error for inpatient PPS services reimbursed under Medicare, using the same improvement project techniques developed and tested under the HCQIP. Task 5 directs the PROs to investigate beneficiary complaints and to conduct specific types of medical record reviews required by statute and regulation to ensure quality oversight of beneficiary care. Task 6 is reserved for pilot projects and experimental topics for quality improvement.

Successes of the HCQIP, to date, include a growing acceptance of the partnership model between providers, PROs, the Federal Government, Medicare beneficiaries, and other stakeholders. The quality indicators and clinical abstraction data have gained increasing credibility in the provider community, resulting in an increased willingness among providers to analyze quality on the basis of statistical patterns of care.

FUTURE DIRECTIONS

Priorities for future development of the HCQIP involve identification of additional clinical areas for attention, improvements in the PRO program infrastructure, and broadening the provider settings of projects. Currently most projects are conducted in hospitals and doctors' offices. Pilot projects are underway to develop intervention programs to improve quality of care for beneficiaries in skilled nursing facilities and home health agencies. Attention to quality of care delivered in these settings can be expected to increase as the utilization of these services increases and as skilled nursing facilities and home health agencies, like acute care hospitals before them, move to a PPS reimbursement system.

Refinements in the information and indicator measurement infrastructures will allow more frequent assessment of quality indicator data than is currently practical. This will improve tracking of quality improvements, allow more rapid and effective feedback, and expedite evaluation of the PROs' performance.

Programmatically, emphasis will continue to be placed upon strengthening existing partnerships and increasing the number and types of partners. Expansion of the partnership base is motivated partly by HCFA's desire to involve all possible resources in its quest to improve quality of care for Medicare beneficiaries. The expansion is also driven by the understanding that the HCQIP partnerships promote improved care of all patients regardless of who reimburses the costs of their care. Finally, partnerships reduce the burden on providers by creating consistent expectations from all purchasers.

The evolution of the PRO program is an important part of HCFA's transition from a financing program to a value based purchaser

of health care. As quality improvement and quality management systems in health care continue to evolve, and as the health care industry and reimbursement structure change, all partners in the HCQIP remain committed to protecting the health care security of Medicare beneficiaries by protecting the trust funds from unnecessary depletion while ensuring that the care received by Medicare beneficiaries is appropriate, necessary, and of the highest quality.

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Medicare: 35 Years of Service

Nancy De Lew, M.A., M.A.P.A

MEDICARE IN 1965

For persons who are trying to understand what we were up to, the first broad point to keep in mind is that all of us who developed Medicare and fought for it had been advocates of universal national health insurance. We all saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the best chance politically. Although the public record contains some explicit denials, we expected Medicare to be a first step toward universal national health insurance, perhaps with "Kiddicare" as another step… President Franklin Roosevelt feared that health insurance was so controversial, because of doctors' opposition, that if he included it in his program for economic security he might lose the entire program. Robert M. Ball, Social Security Commissioner under Presidents Kennedy, Johnson, and Nixon, 1995

Enactment of Medicare

After President Franklin D. Roosevelt decided not to include health insurance in his proposed Social Security Act in 1934, he authorized his staff to do additional work on the proposal, including consultations with a broad array of groups (Corning, 1969). This work was subsequently incorporated into a national health insurance bill introduced in the Congress in 1943—commonly referred to as the Wagner, Murray, Dingell bill (Congressional Quarterly Almanac, 1965). In 1945, President Truman endorsed this bill and became the first president to send a national health insurance bill to the Congress. By the end of Truman's term, in 1952, Medicare was proposed as a scaled down version of national health insurance that would cover all Social Security beneficiaries—the elderly, widows, and orphans. President Eisenhower was opposed to social insurance for health care; in 1954, he proposed a Federal reinsurance plan for private insurance companies. President Kennedy's 1963 proposal for health care for the elderly passed the Senate in 1964, but failed in the House.

After more than a decade of debate on health insurance for the elderly, when Johnson was elected President in 1964, he asked Congress to give Medicare top priority. The earlier efforts towards national health reform finally resulted in coverage for the elderly (Medicare) and the poor (Medicaid), with advocates hoping that coverage would be expanded to other population groups at a later date. In honor of President Truman's leadership, President Johnson flew to the Truman Library in Independence, Missouri to sign the bill into law on July 30, 1965 and presented the first two Medicare cards to former President Truman and Mrs. Truman. Reflecting on the amount of time that had transpired, Johnson noted at the ceremony: "We marvel not simply at the passage of this bill, but what we marvel at is that it took so many years to pass it." (Harris, 1966a).

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Medicare Covers the Elderly in 1965

> *I am one of your old retired teachers that has been forgotten. I am 80 years old and for 10 years I have been living on a bare nothing, two meals a day, one egg, a soup, because I want to be independent. I am of Scotch ancestry, my father fought in the Civil War to the end of the war, therefore, I have it in my blood to be independent and my dignity would not let me go down and be on welfare. And I worked so hard that I have pernicious anemia, $9.95 for a little bottle of liquid for shots, wholesale, I couldn't pay for it.* Hearings of the Subcommittee on Problems of the Aged and Aging of the Committee of Labor and Public Welfare, 1959 (Stevens, 1996)

When Medicare was enacted in 1965, America was in many ways a different place than it is today.

Poverty

In 1965, the elderly were the group most likely to be living in poverty—nearly one in three were poor (Figure 1). Today, the poverty rate for the elderly is similar to that of the age group 18-64—about 1 in 10 are poor. Children are now the group most likely to be living in poverty.

Access to Care for Minorities

> *Before a hospital could be certified for Medicare, it had to do more than have a plan to end discrimination: It had to demonstrate nondiscrimination.* (Ball, 1995)

Segregation denied minorities access to the same health care as white persons. With the passage of the Civil Rights Act (recipients of Federal funds are prohibited from discrimination based on race) in 1964 and Medicare (the source of the Federal funds) in 1965, minorities were able to receive health care in the same hospitals and clinics used by white persons. More than 1,000 Medicare and Public Health Service staff worked with hospitals to make sure they understood they would have to serve all Americans when they signed up for the federally funded Medicare program.

Black hospitalization rates were about 70 percent of white hospitalization rates in the program's first few years. Over the next several years, hospitalization rates rose to comparable levels. In 1963, minorities age 75 or over averaged 4.8 visits to the doctor; by 1971, their visits grew to 7.3, comparable with white utilization rates (National Center for Health Statistics, 1963-1964; 1971).

While Medicare and Medicaid have contributed to considerable progress in the health of minorities, there is still room for improvement as disparities in health status, utilization, and outcomes persist today (Gornick, 2000).

Insurance Coverage

About one-half of America's seniors did not have hospital insurance prior to Medicare. By contrast, 75 percent of adults under age 65 had hospital insurance, primarily through their employer. For the uninsured, needing hospital services could mean going without health care or turning to family, friends, and/or charity to cover medical bills. More than one in four elderly were estimated to go without medical care due to cost concerns (Harris, 1966b).

Medicare, along with other programs, notably Social Security, and a strong economy, have greatly improved the ability of the elderly and the disabled to live without these worries. Medicare covers nearly all of the elderly (about 97 percent), making

them the population group most likely to have health insurance coverage. Today, the groups least likely to have health insurance coverage are young people, Hispanics, and low-wage workers.

Medicare Modeled on Private Insurance Plans

> *We proposed assuring the same level of care for the elderly as was then enjoyed by paying and insured patients; otherwise, we did not intend to disrupt the status quo. Had we advocated anything else, it never would have passed.* (Ball, 1995)

Medicare's benefit package, administration, and payment methods were modeled on the private sector insurance plans prevalent at the time, such as Blue Cross and Blue Shield plans and Aetna's plan for Federal employees (the model for Medicare Part B) (Ball, 1995). Hospitals were allowed to nominate an intermediary (a private insurance company) to do the actual work of bill payment and to be the contact point with the hospitals. Payment methods for facilities (hospitals, nursing home, and home health) were based on reasonable costs. Payments for physicians and other suppliers were based on the lower of the area's prevailing or their own customary or actual charge. These payment methods were designed to make sure Medicare beneficiaries would have access to care on the same terms as privately insured patients. When Medicare began, there was concern, which did not turn out to be the case, that demand for services would strain the capacity of the health care system (Gornick, 1996).

Advantages of this approach included: faster implementation—and with 11 months between enactment and implementation that was no small consideration—and political acceptability: The program looked familiar to providers, insurance companies who would administer the new program, and beneficiaries.

Disadvantages of this approach included: payment methods that turned out to be inflationary, prompting considerable legislative activity in subsequent years to control escalating costs; and using private insurance companies to administer the program without allowing for their selection on a competitive basis, which hampered control of the program. Medicare's benefit package was not designed for some of the specific needs of the elderly. For instance, today, nearly one-third have hearing impairments, nearly 20 percent have visual impairments, and nearly one-third have no natural teeth (National Center for Health Statistics, 1999). Yet, hearing aids, eyeglasses, dentures, outpatient prescription drugs, and long term nursing home care were not generally covered by private insurance and so were not covered by Medicare. There was no limit on beneficiary liability, leaving beneficiaries vulnerable to catastrophic expenses. Nor was there provision in the statute for what are now known as preventive services. Only medical care that was necessary for the treatment of an injury or an illness was covered.

Medicare Covers the Disabled in 1972

In 1972, Congress extended Medicare coverage to the disabled on Social Security Disability Insurance (SSDI) and those with end stage renal disease (ESRD). After receiving SSDI, the disabled have a lengthy waiting period, 24 months, before Medicare coverage begins. In 1973, nearly 2 million persons with disabilities and ESRD enrolled in Medicare. People with ESRD needed very expensive dialysis services to stay alive; concerns about their access to such life-saving services motivat-

ed the expansion of Medicare coverage. ESRD remains the only disease-specific group eligible for Medicare coverage; although others have been proposed, notably human immunodeficiency virus acquired immunodeficiency syndrome, none has been enacted.

LEGISLATIVE HISTORY

When Medicare was enacted, the original statute comprised 58 pages of text. Over the subsequent 35 years, the statute has grown nearly tenfold to more than 500 pages. Highlights by type of reform include:

Eligibility—Significant expansion of eligibility occurred once, when the disabled and those with ESRD were included in 1972. Public-sector employees were required to pay Medicare payroll taxes in the early 1980s.

Financing—Part A revenue sources were expanded several times in the 1980s and 1990s to delay insolvency of the Hospital Insurance (HI) Trust Fund. Part B premiums were initially set at one-half of the program's cost, but due to program spending growing faster than Social Security benefit increases, premiums were limited to the growth in the Social Security cost of living adjustment and are now set by statute at 25 percent of program spending.

Payment Policy—Most of the major legislative activity in the 1980s and 1990s focused on payment policy, in an effort to control rapidly escalating program spending. Hospitals and other Part A providers were moved from cost-based payment to prospective payment systems (PPSs). Physicians and many other Part B suppliers were moved from charge-based payment to fee schedules. Managed care plans' risk-based payment was modified at the end of the 1990s to reduce the geographic variation in payment amounts and to adjust for the relative health status of their patients.

Benefits—The benefit package was substantially updated in the 1988 Medicare Catastrophic Coverage Act (MCCA) to include coverage of outpatient prescription drugs and other changes. It was repealed in 1989 after higher income elderly protested a new tax to partially finance the new benefits. As the importance of preventive benefits became clear, many have been added by the Congress on an incremental basis. Other changes in covered services have included the addition of hospice care, improved coverage for mental health services, and expanded home health benefits.

Chronology of Major Legislative Activity

July 30, 1965—The Medicare program, authorized under Title XVIII of the Social Security Act, was enacted to provide health insurance coverage for the elderly.

July 1, 1966—Medicare benefits began for more than 19 million individuals enrolled in the program.

1972— Medicare eligibility was extended to individuals under age 65 with long-term disabilities after 24 months of Social Security disability benefits and to individuals with ESRD after a 3-month course of dialysis; 2 million such individuals enrolled in the program in 1973.

1980—The home health benefit was broadened; the prior hospitalization requirement was eliminated as was the limit on visits. Medicare supplemental insurance, also called "medigap," was brought under Federal oversight.

1982—A prospective risk-contracting option for health maintenance organizations (HMOs) was added to facilitate plan participation. Hospice benefits for the terminally ill were covered. Medicare was made secondary payer for aged workers

and their spouses. Medicare utilization and quality-control peer review organizations were established. Rate-of-increase limits were placed on inpatient hospital services.

1983—An inpatient hospital PPS, in which a pre-determined rate is paid based on patients' diagnoses, was adopted to replace cost-based payments. (The PPS was subsequently adopted by other payers and other countries.) Federal employees were required to pay the HI payroll tax.

1985—Medicare coverage was made mandatory for newly hired State and local government employees.

1988—The MCCA was the largest expansion of Medicare benefits since the program was enacted. It included an outpatient prescription drug benefit, a cap on patient liability for catastrophic medical expenses, expanded skilled nursing facility (SNF) benefits, and modifications to the cost-sharing and episode-of-illness provisions of Part A. Expansions were funded in part by an increase in the Part B premium and a new supplemental income-related premium for Part A beneficiaries. Under Medicaid, States were required to provide assistance with Medicare cost-sharing to low-income Medicare beneficiaries.

1989—The MCCA was repealed after higher-income elderly protested the new tax. A new fee schedule for physician services, called the resource-based relative value scale (RBRVS), was enacted. Physicians were required to submit bills to Medicare on behalf of all Medicare patients. Beneficiary liability for physician bills, above and beyond what Medicare pays, was limited. (The RBRVS was subsequently adopted by other payers.)

1990—Additional Federal standards for Medicare supplemental insurance policies were added. The Part B deductible was increased and prospective payments for inpatient hospital capital expenditures replaced payments based on reasonable costs. Screening mammography was covered and partial hospitalization services in community mental health centers were covered.

1993—The HI payroll tax was applied to all wages, rather than the lower Social Security capped amount; and a new tax on Social Security benefits was imposed above a threshold, with revenues placed in the HI Trust Fund. Under Medicaid, States were required to cover Medicare Part B premiums for specified low-income Medicare beneficiaries.

1996—The Health Insurance Portability and Accountability Act contained a number of provisions regarding fraud and abuse and established a mandatory appropriation to secure stable funding for program integrity activities and opened program integrity contracts to competitive procurement.

1997—The Balanced Budget Act (BBA) included the most extensive legislative changes since the program was enacted. It:

- Reduced payment increases to providers, thereby extending solvency of the HI Trust Fund.
- Established Medicare+Choice, a new array of managed care and other health plan choices for beneficiaries, with a coordinated annual open enrollment process, a major new beneficiary education campaign, and significant changes in payment rules for health plans.
- Expanded coverage of preventive benefits.
- Created new home health, SNF, inpatient rehabilitation and outpatient hospital PPSs for Medicare services to improve payment accuracy and to help further restrain the growth of health care spending.
- Created new approaches to payment and service delivery through research and demonstrations.

1999—The Balanced Budget Refinement Act increased payments for some providers relative to the payment reductions in the BBA 1997.

MEDICARE IN 2000

During the past 35 years, Medicare has provided health care coverage to more than 93 million elderly and persons with disabilities; more than 39 million are alive today. As a consequence, Medicare has made important contributions to improvements in health status for elderly and disabled beneficiaries.

Medicare Beneficiaries

The Medicare program provides health insurance coverage to a diverse and growing segment of the U.S. population (Figure 2). Over its history, the population that is covered under the program has not only expanded in numbers, but has grown more complex in composition and health care needs. More than 19 million elderly entered Medicare in 1966; today, Medicare provides insurance coverage for 34 million older Americans. The number of elderly and disabled enrollees has more than doubled since 1965 to 39 million today. The Medicare population is expected to nearly double again to more than 77 million in 2030 (22 percent of the population) (Figures 2 and 3).

Medicare quickly expanded access to care for the elderly. Hospital discharges averaged 190 per 1,000 elderly in 1964 and 350 per 1,000 by 1973; the proportion of elderly using physician services jumped from 68 to 76 percent from 1963-1970. Currently, more than 94 percent of elderly beneficiaries receive a health care service paid for by Medicare. Similarly, Medicare has improved access for disabled enrollees.

Sex, Marital Status, Race, and Age

Within the elderly population, there are more females than males enrolled in Medicare, primarily because of the longer life expectancy of females. The proportion that is female increases with age: females are more than 70 percent of the population age 85 or over, according to the Medicare Current Beneficiary Survey. However, the relationship is reversed in the disabled population, where more males are enrolled, reflecting the makeup of the SSDI program population.

Older females are much more likely to be widowed and to live alone than older males due to a number of factors, including females' longer life expectancy, the tendency for females to marry males who are slightly older, and higher remarriage rates for widowed males. Among people age 85 or over, about one-half of the males were still married compared with only 13 percent of the females. (Federal Interagency Forum on Aging-Related Statistics, 2000).

The majority of the elderly Medicare population is white (84 percent), black comprise 7 percent, Hispanic 6 percent, and all other races/ethnicities 3 percent. Among disabled enrollees, 69 percent are white, 17 percent are black, and 11 percent are Hispanic.

The living arrangements of the elderly vary by racial and ethnic group. Older white females are much less likely to live with other relatives than older minority females (15 percent compared with 30-40 percent) (Federal Interagency Forum on Aging-Related Statistics, 2000). Living alone is a risk factor for nursing home placement, as the elderly grow older.

Over 13 percent, or 4.5 million, of the Medicare elderly population is age 85 or over. The U.S. Census Bureau estimates that more than 70,000 Americans are age 100 or over (U.S. Bureau of the Census, 1999).

Economic Status

Although the economic status of the elderly as a group has improved over the past 35 years, most elderly individuals have modest incomes. Reflecting the income

distribution of beneficiaries, the majority of Medicare spending is for beneficiaries with modest incomes: 33 percent of program spending is on behalf of those with incomes of less than $10,000 (Figure 4).

Many elderly Medicare beneficiaries depend upon their Social Security benefits for much of their income. The reliance on Social Security income is greater among single elderly individuals, and increases dramatically as individuals age: Social Security is one-half of the average 85 year old's income. In 1998, Social Security benefits provided about two-fifths of the income of older persons; asset income, pensions, and personal earnings each provided about one-fifth of total income (Federal Interagency Forum on Aging-Related Statistics, 2000).

Nearly 30 percent of Medicare beneficiaries live alone, and they are disproportionately female and poor: 72 percent are female, 60 percent have incomes under $15,000. About 15 percent of those who live alone are age 85 or over (Figure 5).

Health, Chronic Conditions, and Functional Status

Nearly 30 percent of the elderly reported that they were in fair or poor health, compared with 17 percent of those aged 45-64. The percentage reporting fair or poor health was higher for minority groups and increased with age: About 35 percent of those age 85 or over considered themselves in relatively poor health. (National Center for Health Statistics, 1999).

Differences in self-reported health status are reflected in Medicare per capita spending. Not surprisingly, the beneficiaries who reported their health status as poor spent five times as much as the beneficiaries reporting excellent health. Medicare per capita spending also increases as functional status declines.

The incidence of chronic conditions among the elderly, defined as prolonged illnesses that are rarely cured completely, varies significantly by age and racial group. For instance, about 1 in 10 of the elderly has diabetes. However, both the incidence of diabetes and the mortality rates from it are higher for minority groups: Diabetes is the third leading cause of death for elderly American Indians, the fourth leading cause of death among elderly black and Hispanic persons, and the sixth leading cause of death for white persons (National Center for Health Statistics, 1999). The majority of the elderly report arthritis, which has important implications for the ability to care for oneself while living in the community. About 1 in 10 of those who need assistance with the tasks of daily living report arthritis as one of the causes of their need for assistance (National Center for Health Statistics, 1999). Hypertension and respiratory illnesses each affect about one in three of the elderly. About one in four of the elderly have heart disease (National Center for Health Statistics, 1999).

Nearly one in three of the elderly reported limitations with 1 or more activities of daily living (ADLs).[1] About 11 percent of the elderly report limitations in instrumental activities of daily living (IADLs).[2] About 30 percent of the disabled Medicare beneficiaries had difficulties with 1 or more ADLs (Figure 6).

MEDICARE SPENDING

Medicare benefit spending for fiscal year (FY) 1967 was $3.3 billion and for FY 1999 is estimated at nearly $212 billion (Figure 7). The largest shares of spending are for inpatient hospital services (48 percent) and physician services (27 percent) (Figure 8). As medical care has moved to

[1] ADLs, e.g. eating, bathing, toileting.

[2] IADLs, e.g. making telephone call, paying bills, shopping.

the outpatient setting, these numbers have changed significantly over time. For example, inpatient hospital services accounted for a much higher share of spending, 67 percent, in 1970.

Medicare Spending per Beneficiary

In FY 1999 Medicare spent an average of $5,410 per beneficiary. The amount varies on the basis of eligibility and masks considerable variation across individuals. Like other insurance programs, a small percentage of beneficiaries account for a disproportionate share of Medicare spending. More than 75 percent of Medicare's payments for elderly and disabled beneficiaries in 1997 were spent on the 15 percent of enrollees who incurred Medicare payments of $10,000 or more. A similar distribution of payments has existed for much of the program's history.

Historical Spending Growth Comparison

Policymakers have often gauged Medicare's success by measuring program spending against the growth in private health insurance (PHI) spending, the source of insurance for the majority of the working population under age 65. Medicare and PHI are the two largest sources of payment for health care.

Over the 1969-1998 period, Medicare and PHI benefits have grown at similar average annual rates—10.0 and 11.2 percent respectively (Figure 9). During selected periods, however, the growth rates have diverged dramatically. Divergence in growth rates is not unusual between the two major health care payers. Growth rates have often differed, with Medicare alternatively being charged with not "paying its fair share" or "cost-shifting" (1985-1991, 1997-1998) or with being "unable to control costs" (1993-1997). Private and public sector forces act to bring spending growth into balance over the long run.

SUPPLEMENTAL INSURANCE, ACCESS TO CARE, AND OUT-OF-POCKET SPENDING

While Medicare is a very important program for the elderly, its benefit package has not kept up with changes in PHI coverage and consequently is less generous than most health plans offered today by large employers. Only about one-half of the personal health care expenditures of the elderly (not including Medicare Part B or private supplemental insurance premiums) are paid by Medicare (Figure 10). Total annual health care spending, from all sources, averaged $9,340 per Medicare beneficiary in 1997. This total masks considerable variation: For instance, total health spending for those who lived in the community averaged $7,181, compared with $43,131 for those who lived in a facility.

Supplemental Insurance

> *Medicare has been a life saver with a stroke, two heart attacks and removal of one kidney. There is no way I could've paid for all of that without the help of Medicare and supplemental insurance.* Medicare beneficiary in Richmond, VA. (Health Care Financing Administration, 2000.)

Most beneficiaries have other supplemental insurance (e.g., private medigap policies, retiree coverage, or Medicaid) to supplement their Medicare benefits (Figure 11). About 14 percent of Medicare beneficiaries have no supplemental coverage; groups most likely to rely solely on Medicare are the disabled, minorities, and those with low incomes. Supplemental

insurance reduces beneficiaries' out-of-pocket expenditures associated with the use of health care services including Medicare cost sharing.

The majority (approximately 67 percent) of Medicare's elderly beneficiaries in fee-for-service (FFS) have private supplemental insurance, either through an employer and/or purchased individually. Most of the elderly enrolled in managed care plans (about 75 percent) do not have any other type of coverage, in part because managed care plans tend to have more generous benefits, making a medigap policy duplicative.

While Federal law guarantees the availability of supplemental insurance policies to elderly beneficiaries (through a limited 6-month open enrollment period upon reaching age 65), only a few States guarantee medigap availability for the Medicare disabled population. This may account in part for the lower levels of medigap coverage for the disabled.

Out-of-Pocket Health Care Spending

> *I'm thankful for Medicare, but I do have a problem with prescriptions. I have supplemental insurance, but it pays some of it but not that much. That's what really gets me. Now, you go to the drugstore to get medicine—$80, well…*Female Medicare beneficiary in Richmond, VA (Health Care Financing Administration, 2000.)

Medicare and other sources of health insurance have covered a growing share of the Nation's health spending on the elderly. Before Medicare was enacted, the elderly paid 53 percent of the cost of their health care; that share dropped to 29 percent in 1975 and 18 percent in 1997 (Social Security Administration, 1976; Health Care Financing Administration, 2000). The elderly's health costs consumed 24 percent of the average Social Security check shortly before Medicare; by 1975, that share dropped to 17 percent (Social Security Administration, 1976.)

The elderly spend a higher proportion of their income on health than the general population, both because they have higher health care costs (on average four times that of the under age 65 population) and because they have lower incomes. Lower-income elderly spend a higher proportion of their income on health than higher-income elderly: Those with incomes below $10,000 spent one-quarter of their income on health care, those with incomes above $70,000 spent about 5 percent of their income on health care (Figure 12).

The vast majority of beneficiary out-of-pocket spending on health care is concentrated on three services: long- term facility care accounts for the largest share at 44 percent, with outpatient prescription drugs tied with spending on physician and other supplier services at nearly 19 percent each (Figure 13).

Vulnerable Populations and Access to Care

> *If it was not for Medicare, I could not go to the doctor.* Medicare Beneficiary (Health Care Financing Administration, 1999.)

Certain vulnerable populations historically have experienced problems with access to care. The groups include the disabled, Medicare beneficiaries who are eligible for Medicaid (dual eligibles), beneficiaries with low incomes, those age 85 or over, minorities, persons living in rural areas, or in areas designated as health professional shortage areas. A variety of population groups have significantly higher rates of hospitalization for "ambulatory care sensitive" conditions. These are medical conditions that are responsive to good and continuous ambulatory care, like asthma or

diabetes. For instance, black beneficiaries are more than three times as likely as white beneficiaries to have a lower limb amputated—often a result of diabetes complications; they are more than two times as likely as white beneficiaries to be treated for wound infections and skin breakdowns, also associated with poor quality care (Gornick, 2000).

Administrative Costs

Medicare's overall administrative costs are less than 2 percent of total benefit payments (Figure 14). Medicare's administrative costs are significantly lower than private insurers, which the Blue Cross/Blue Shield Association estimates at 12 percent for their plans. Medicare's administrative costs have been declining, reflecting greater efficiency through high levels of electronic claims processing.

In FY 1999 Medicare processed over 850 million claims at a unit cost per claim of $.84 for Part A fiscal intermediaries and $.77 for Part B carriers (Figure 15). Cost per Part A claim has declined by 50 percent in nominal dollars (if the dollars were adjusted for inflation, the decline would be even larger) over the past 10 years, while the number of claims has doubled.

Electronic claims processing is a key reason that the cost per claim has significantly declined (Figure 16). Electronic submission of claims increased from 74 percent of Part A claims in 1990 to 97 percent in 1999, Part B rates rose from 36 percent to 80 percent over the same period.

MEDICARE+CHOICE

The vast majority of Medicare beneficiaries (83 percent) rely on Medicare's traditional FFS benefits, while 15 percent are enrolled in Medicare+Choice plans. By contrast, in the private sector nearly 80 percent of insured individuals receive their coverage through a managed care plan such as a preferred provider organization (PPO), point-of-service plan, or traditional HMO.

Enrollment in Medicare+Choice

Enrollment in Medicare+Choice, and before that under the risk HMO program, increased every year since the beginning of the risk program in 1985. Increases in enrollment accelerated significantly in the late 1990s, though in recent months, growth has tapered off or even declined. By the end of 1999, 17 percent of Medicare beneficiaries were enrolled in risk HMOs (Figure 17). The trend in Medicare HMO enrollment is similar to that of the private sector.

Access Under Medicare+Choice

HMO interest in Medicare contracting resulted in dramatic increases in the number of contractors in the mid-1990s. The number of risk contracts more than tripled from 1990-1997. Over the decade of the 1990s, the increase in the availability of plans with benefits more generous than FFS Medicare, coupled with increasing medigap premiums, led more Medicare beneficiaries to enroll in HMOs. Today, about 70 percent of Medicare beneficiaries live in an area with at least one Medicare +Choice plan available. Medicare+Choice enrollment is highly concentrated in certain areas of the country and in certain plans.

Medicare+Choice enrollees are less likely to be eligible for both Medicare and Medicaid, and are less likely to be institutionalized. Medicare+Choice enrollees also have better-than-average health and are less likely to be very poor or very wealthy.

Benefits Available to Medicare+Choice Enrollees

Most Medicare+Choice enrollees are provided with extra services not covered by Medicare, such as preventive care beyond what Medicare covers and prescription drugs. Some Medicare+Choice plans charge no premium, and in almost all cases, Medicare+Choice premiums are significantly lower than medigap premiums for similar benefits.

MEDICARE BENEFICIARY SATISFACTION

Medicare beneficiaries, whether enrolled in FFS or a Medicare+Choice plan, are generally well satisfied with their medical care (Figure 18). Members of Medicare+ Choice plans are somewhat more likely to be satisfied or very satisfied with their out-of-pocket costs than FFS beneficiaries (94 percent versus 87 percent). About 13 percent of FFS beneficiaries were unsatisfied with their out-of-pocket costs, compared with 6 percent of Medicare+Choice enrollees. While Medicare+ Choice members were slightly more unhappy about their ability to get answers to their questions by telephone, they found the ease of getting to a doctor and the availability of care comparable with that experienced by FFS beneficiaries.

MEDICARE'S ROLE IN THE BROADER HEALTH SYSTEM

Medicare covers about 14 percent of the population, but because of the extensive health care needs of the elderly and disabled, finances about 21 percent of the Nation's health spending, up from 11 percent in 1970 (Figure 19). Medicare's share varies significantly by type of service and has changed over time as Medicare has become a more important source of financing of health care. For example, in 1970, Medicare paid for 19 percent of all hospital spending; by 1998, Medicare's share rose to 32 percent.

Medicare spending finances care for its beneficiaries and also has important ramifications for the health system as a whole. Special payments for rural, inner-city, and teaching hospitals and other safety net providers help to guarantee access to care for other population groups who live in those areas. Medicare's role in quality assurance in hospitals, nursing homes, and other settings helps to assure that all Americans receive high-quality health care services from those providers. Medicare plays an important role in educating the Nation's physicians by financing a portion of the costs of graduate medical education at teaching hospitals, where much of the country's medical research occurs.

Medicare spending is a growing share of the Federal Government's budget: This year, it will account for 12 percent of the budget, compared with 10 percent in 1993 and 4 percent in 1970 (De Lew, 1995).

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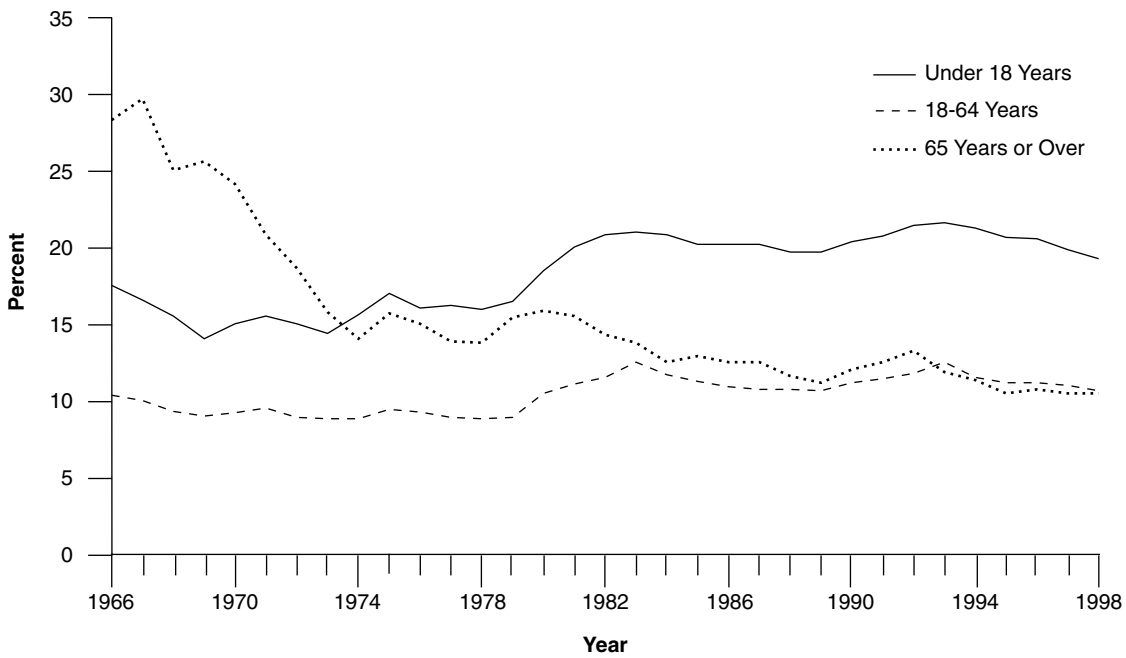
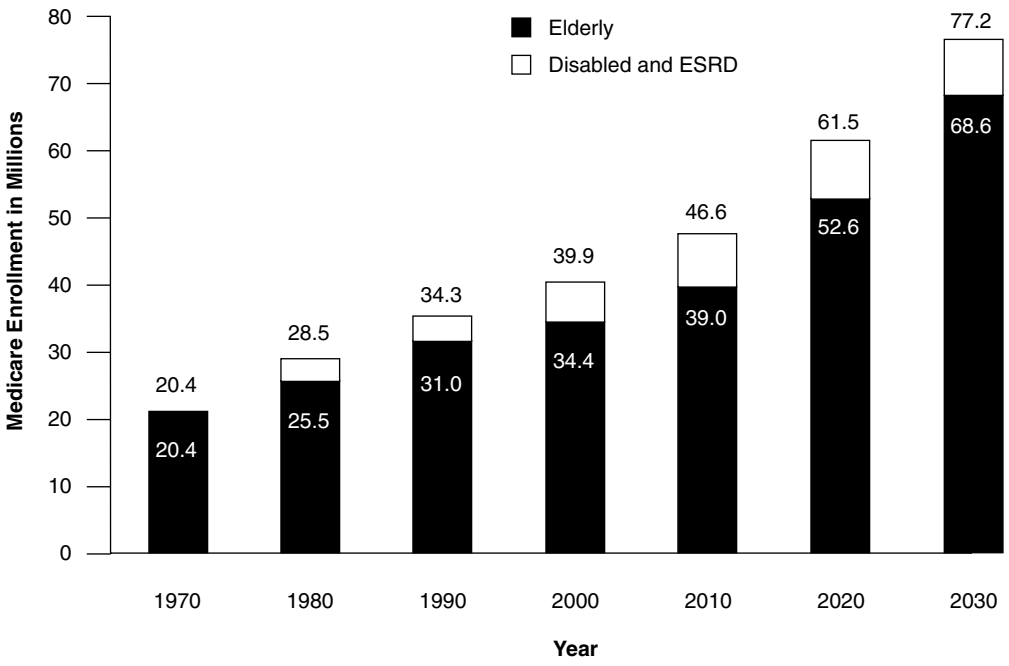
Figure 1
Poverty Rates, by Age: 1966-1998



NOTE: Improvements in Social Security and private pension coverage are important factors in the decline of the elderly's poverty rate.

SOURCE: (U.S. Bureau of the Census, 1999.)

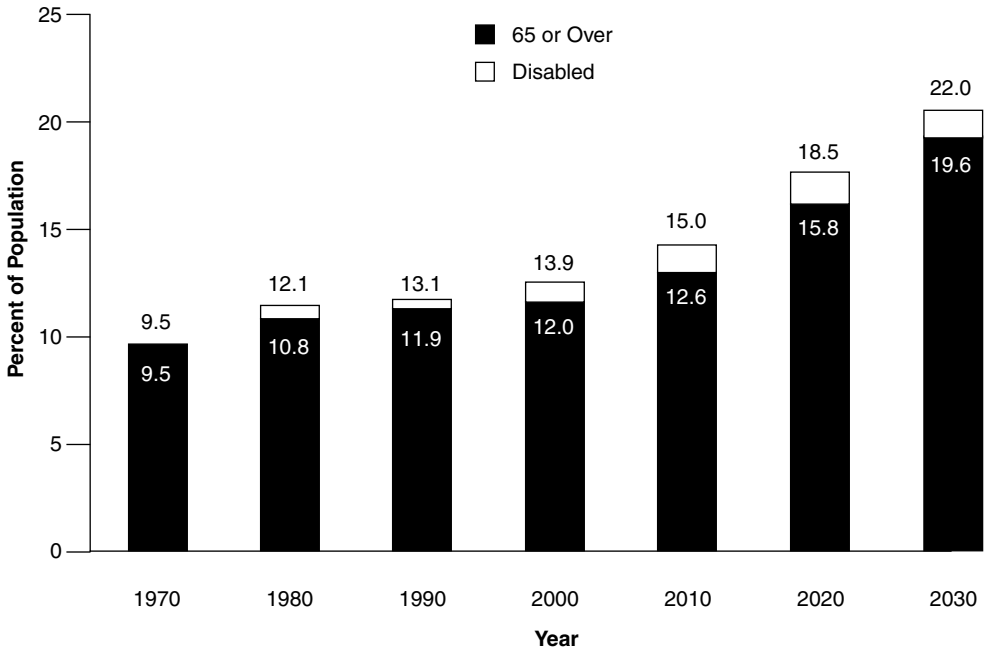
Figure 2
Number of Medicare Beneficiaries: 1970-2030



NOTES: ESRD is end stage renal disease. The number of Medicare beneficiaries will nearly double by 2030.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

Figure 3
Aging of the U.S. Population: 1970-2030

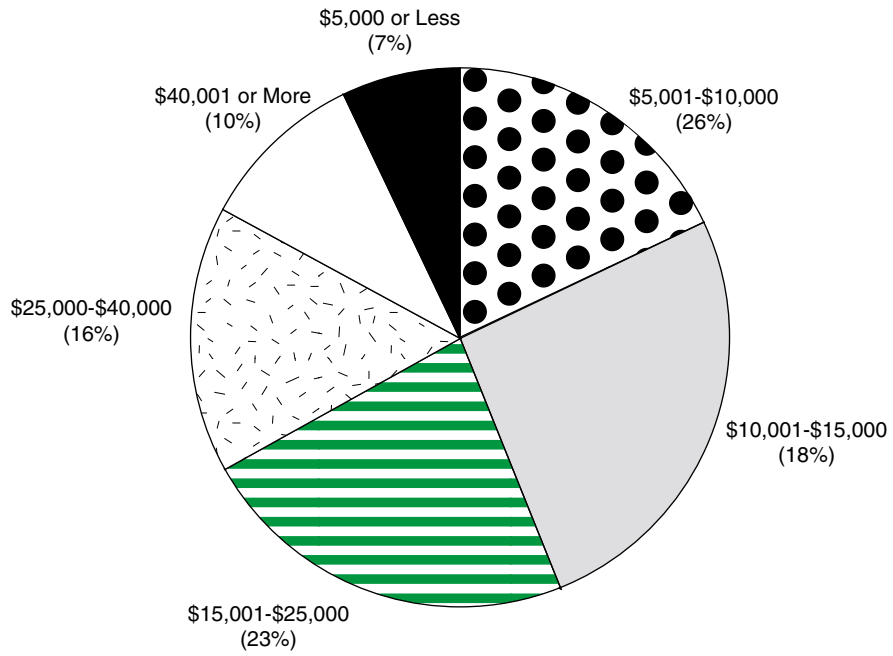


NOTE: The U.S. population will age rapidly through 2030, when 22 percent of the population will be eligible for Medicare.

SOURCE: Social Security Administration, Office of the Actuary: Data from the Office of the Actuary, 2000.

Figure 4

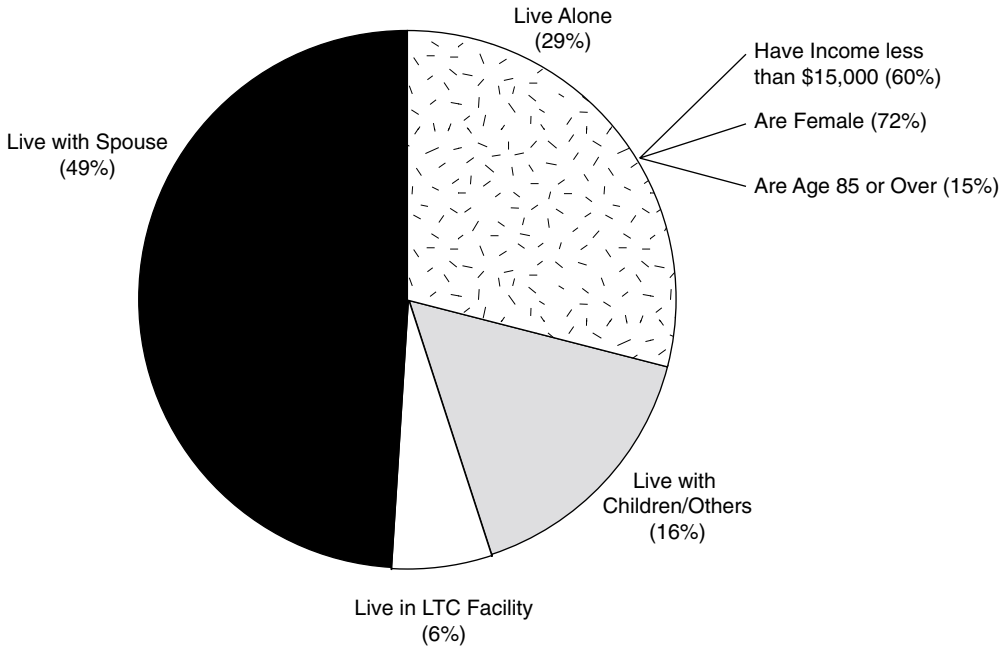
Medicare Spending for Fee-for-Service Beneficiaries, by Income: 1997



NOTE: Seventy-four percent of Medicare expenditures are on behalf of individuals with annual income of $25,000 or less.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data from the Medicare Current Beneficiary Survey, 1997.

Figure 5
Living Arrangements of Medicare Beneficiaries: 1998

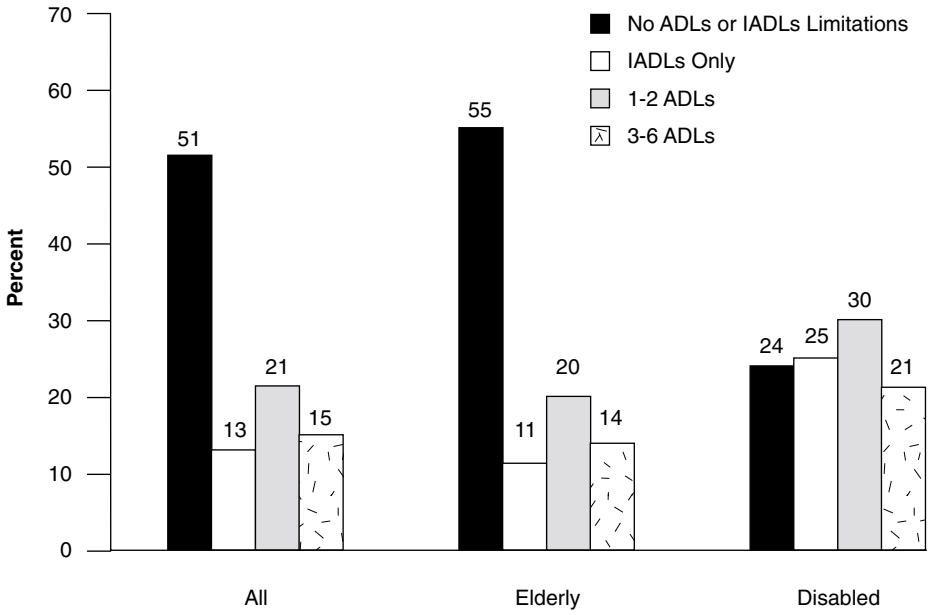


NOTES: LTC is long-term care. Nearly 30 percent of Medicare beneficiaries live alone.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data from the Medicare Current Beneficiary Survey, 1998.

Figure 6

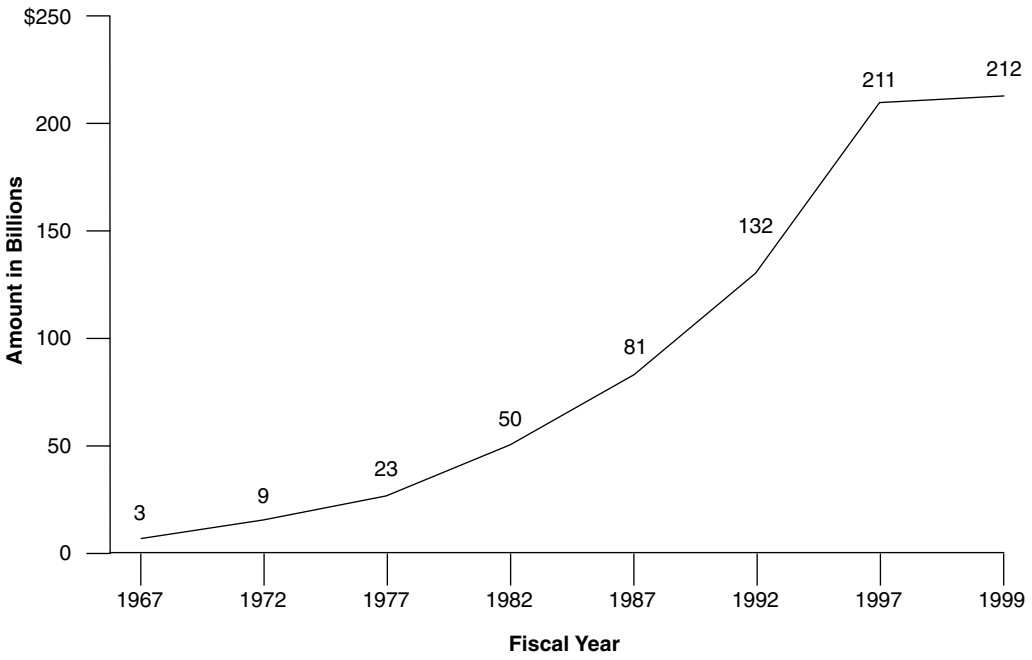
Distribution of Medicare Enrollees, by Functional Status: 1998



NOTES: ADL is activities of daily living (e.g., eating, bathing). IADL is instrumental activities of daily living (e.g., shopping, use of telephone, cleaning). More than one-third of the Medicare population needs assistance with at least 1 ADL.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data from the Medicare Current Beneficiary Survey, 1998.

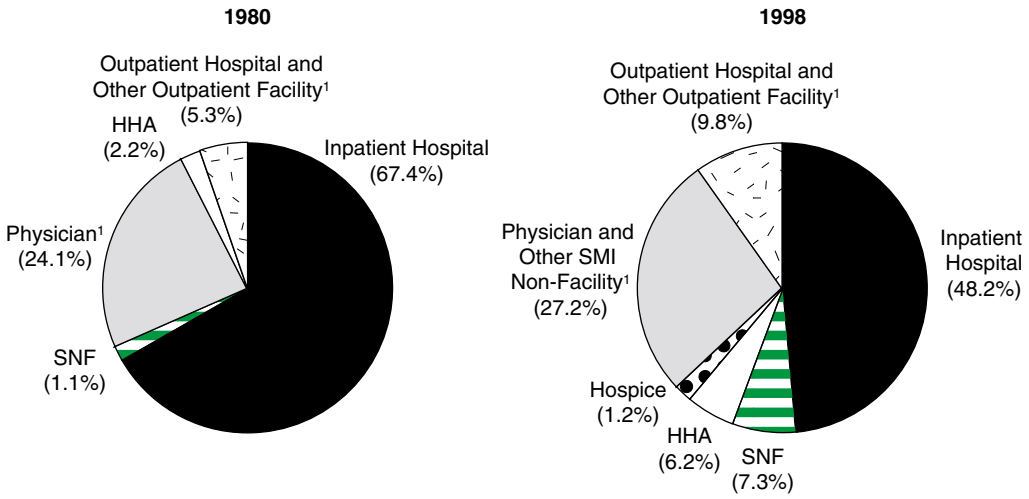
Figure 7
Medicare Spending: Fiscal Years 1967-1999



NOTE: Medicare spending grew from $3.3 billion in 1967 to nearly $212 billion in 1999.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

Figure 8
Where the Medicare Dollar Went: 1980 and 1998



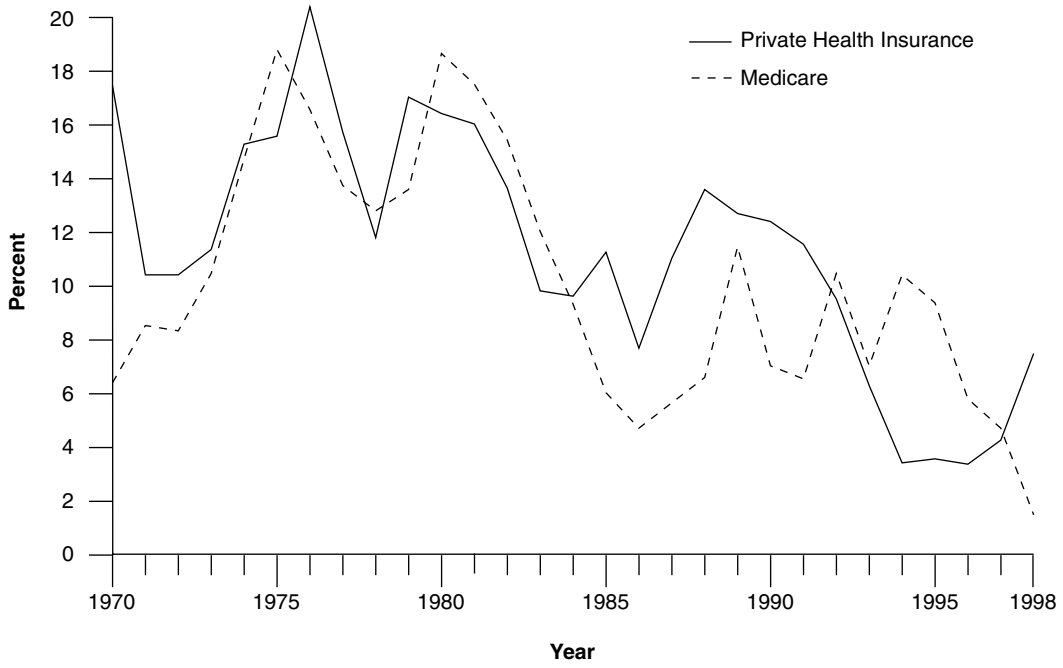
[1] The definition of these categories has changed over time, so they are not directly comparable over the period. Managed care spending is incorporated within the categories.

NOTES: HHA is home health agency. SNF is skilled nursing facility. SMI is supplementary medical insurance. Medicare spending is shifting away from inpatient hospital services toward outpatient services and other providers.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

Figure 9

Rate of Growth in Per Enrollee Medicare and Private Health Insurance Spending: 1970-1998

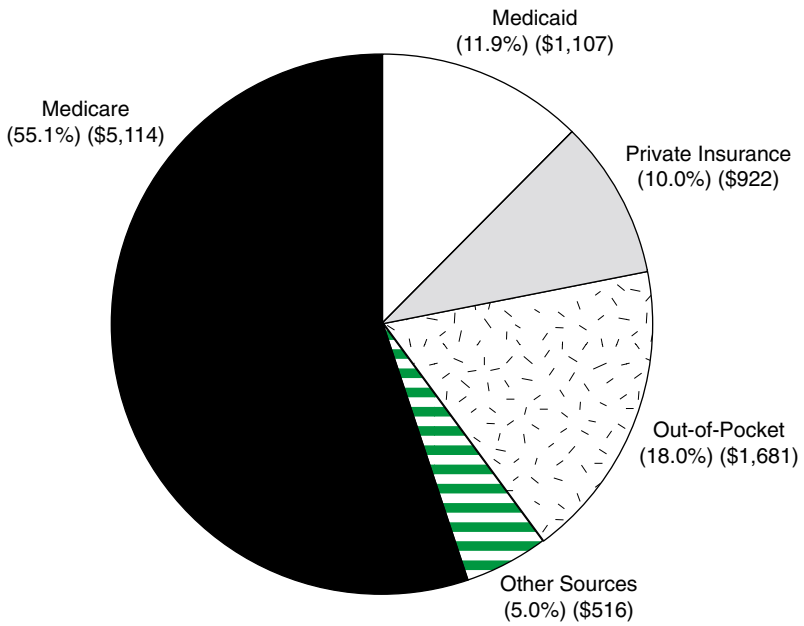


NOTES: Medicare and private health insurance (PHI) are the two largest payers of health care. In 1998, benefits per enrollee under Medicare increased 1.2 percent, while those under private health insurance increased 7.2 percent, respectively. This represents a reversal of trends experienced from 1992-1997.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the National Health Statistics Group, 2000.

Figure 10

Sources of Payment for Medicare Beneficiaries' Use of Medical Services: 1997



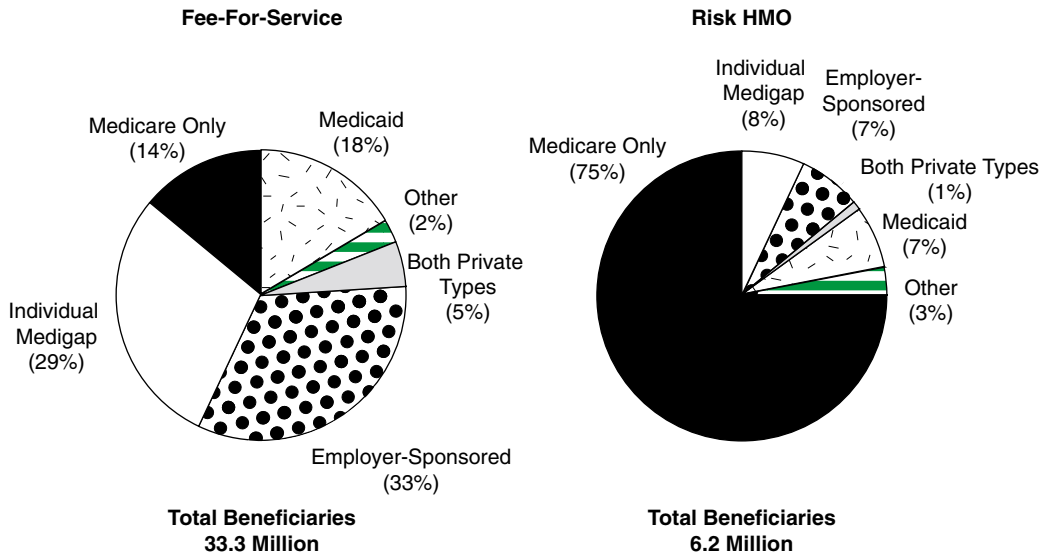
Total Average Spending Per Beneficiary $9,340

NOTES: Medicare pays about one-half the total cost of beneficiaries' medical care. Beneficiary out-of-pocket spending does not include their payments for Medicare Part B premiums, private insurance premiums, or health maintenance organization premiums

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data from the Medicare Current Beneficiary Survey, 1997.

Figure 11

Type of Supplemental Health Insurance Held, by Medicare Beneficiaries: 1998

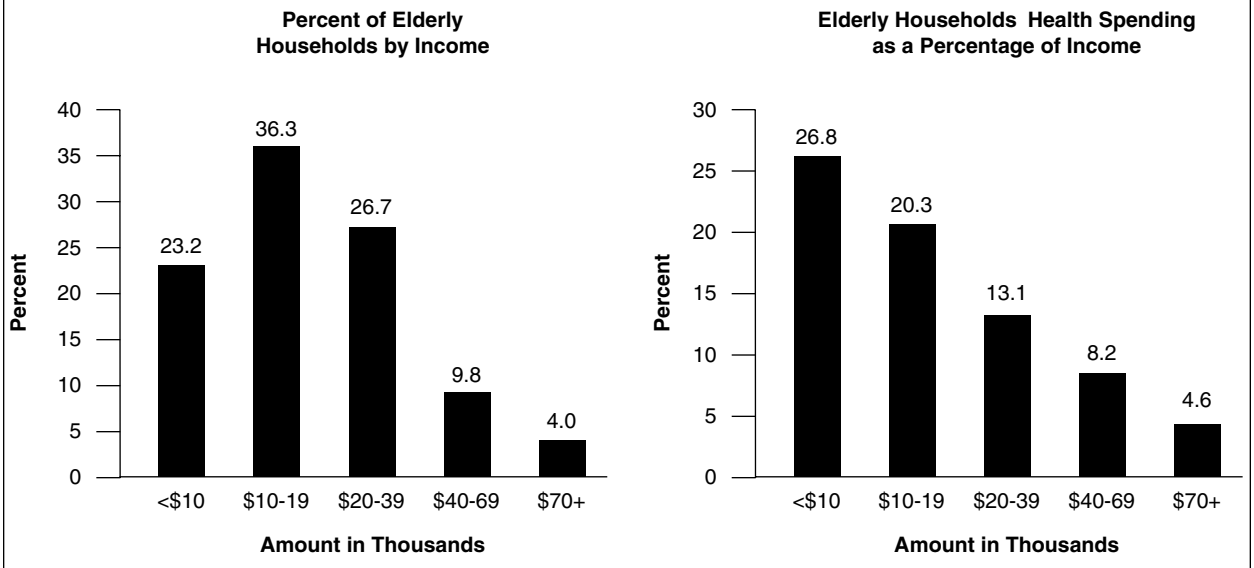


NOTES: HMO is health maintenance organization. Most beneficiaries using fee-for-service have private, supplemental health plans; however, most elderly beneficiaries enrolled in managed care plans have no other supplemental coverage.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data from the Medicare Current Beneficiary Survey, 1998.

Figure 12

Elderly Health Spending as a Percentage of Income: 1998

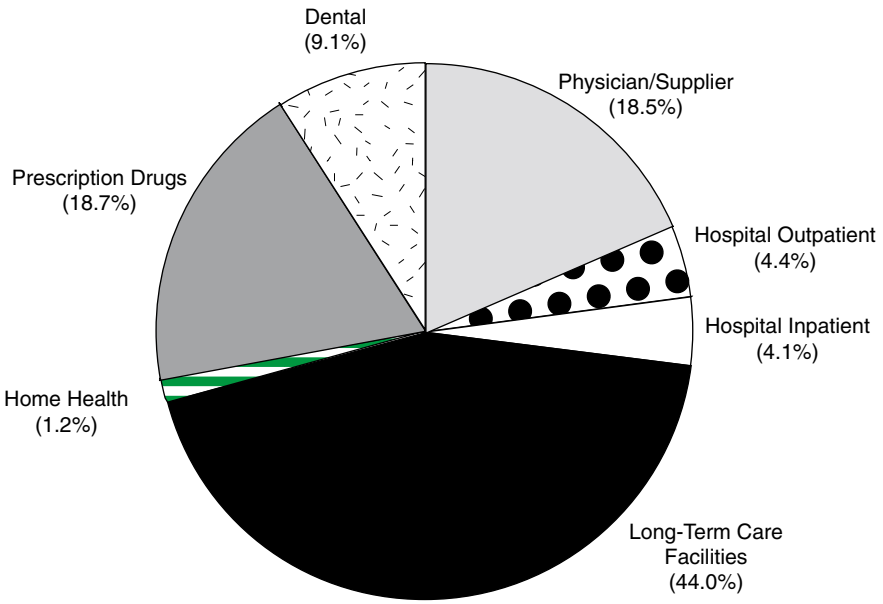


NOTE: Most elderly households have income below $40,000 and they spend a greater percentage of their income on health than more affluent elderly households.

SOURCE: U.S. Bureau of Labor Statistics: Consumer Expenditure Survey, 1997-1998. U.S. Government Printing Office. Washington, DC.

Figure 13

Distribution of Beneficiary Out-of-Pocket[1] Expenses: 1997



Total Out-of-Pocket Expenditures
$66.8 Billion

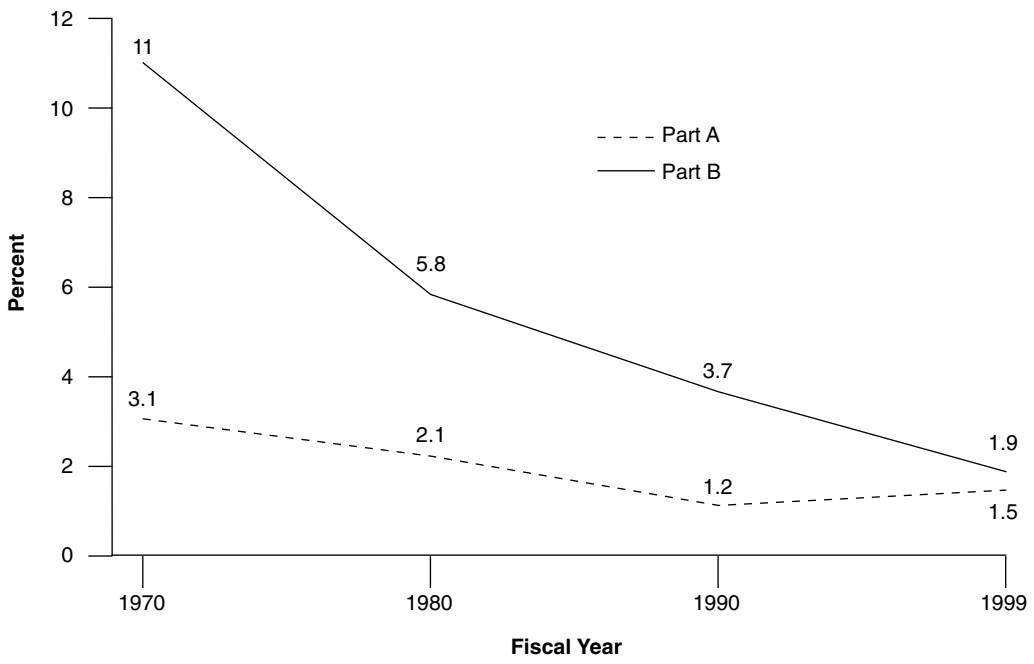
[1] Beneficiary out-of-pocket spending does not include their payments for Medicare Part B premiums, private insurance premiums, or health maintenance organization premiums.

NOTE: Institutional long-term care services account for the highest share of beneficiary out-of-pocket payments, followed by outpatient prescription drugs, and physician services.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data from the Medicare Current Beneficiary Survey, 1997.

Figure 14

Medicare Administrative Expenses as a Percent of Benefit Payments: Fiscal Years 1970-1999

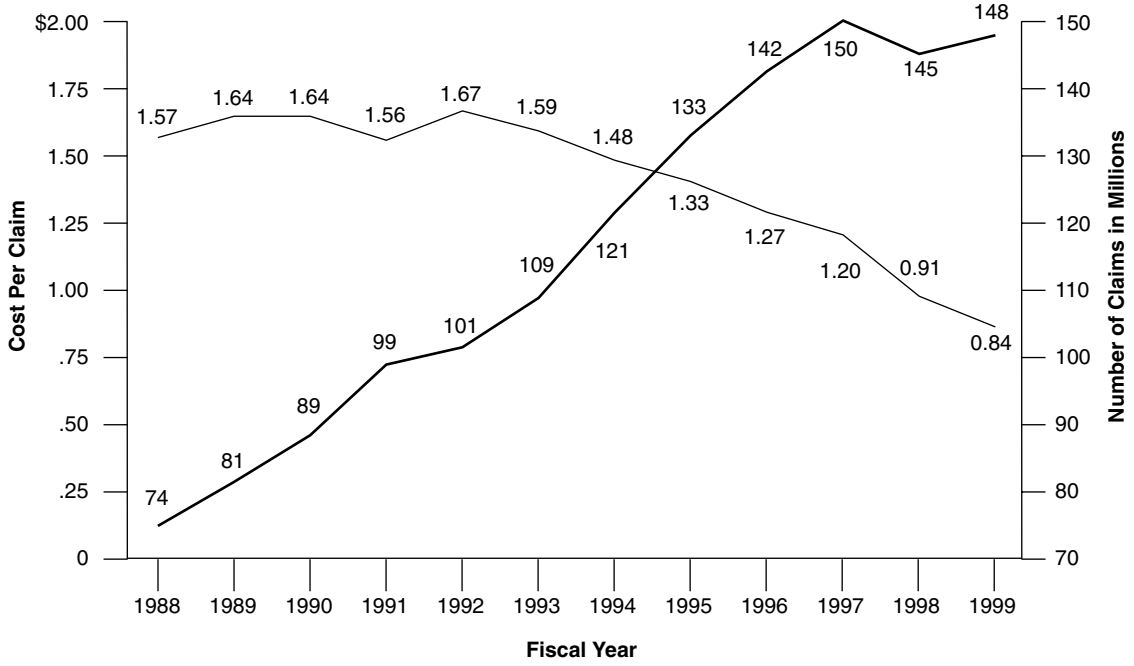


NOTE: Medicare's administrative costs have been declining as a percentage of total program spending.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

Figure 15

Medicare Part A Cost Per Claim and Number of Claims: Fiscal Years, 1988-1999

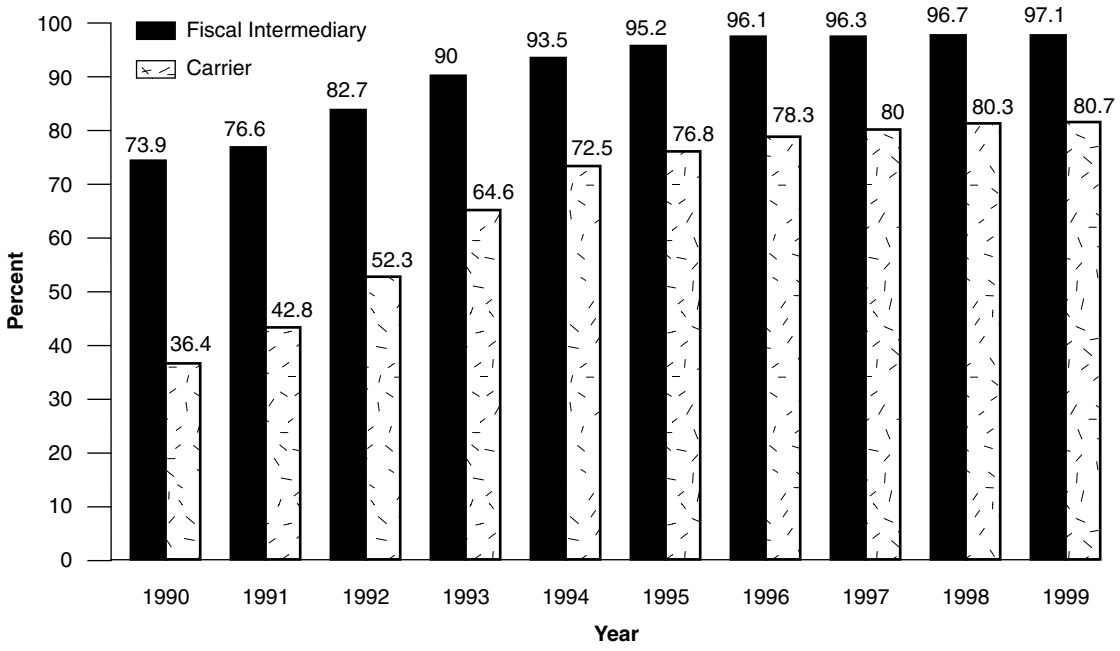


NOTES: 1999 data are preliminary estimates. Cost per claim is in nominal dollars. Over the last decade, the number of Part A claims has doubled while the cost of processing each claim has been cut by one-half.

SOURCE: Health Care Financing Administration, Center for Beneficiary Services: Data from the Medicare Contractor Management Group, 2000.

Figure 16

Percent of Medicare Electronic Claims, by Calendar Years: 1990-1999

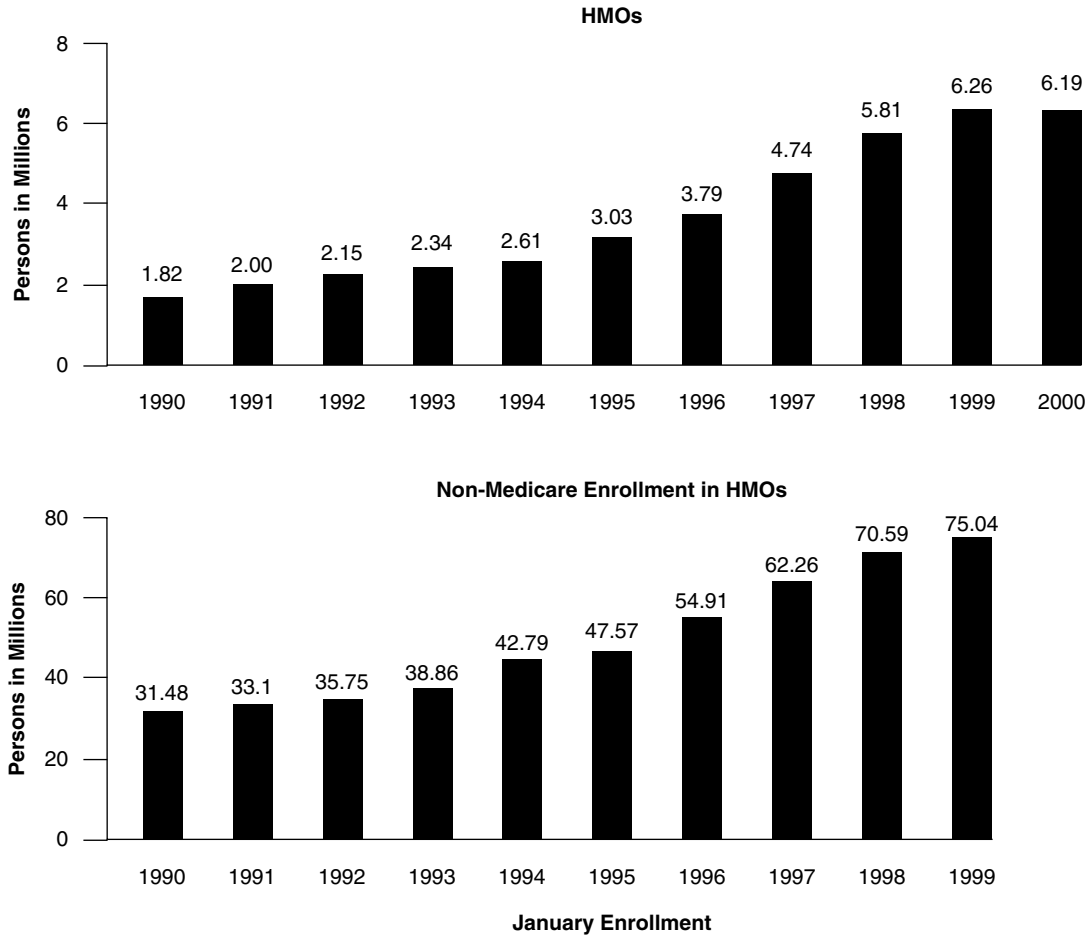


NOTE: The rate of electronic submission of Medicare claims has grown considerably over the past decade.

SOURCE: Health Care Financing Administration, Center for Beneficiary Services: Data from the Medicare Contractor Management Group, 2000.

Figure 17

Medicare and Non-Medicare Health Maintenance Organization (HMO) Enrollment Growth: 1990-1999

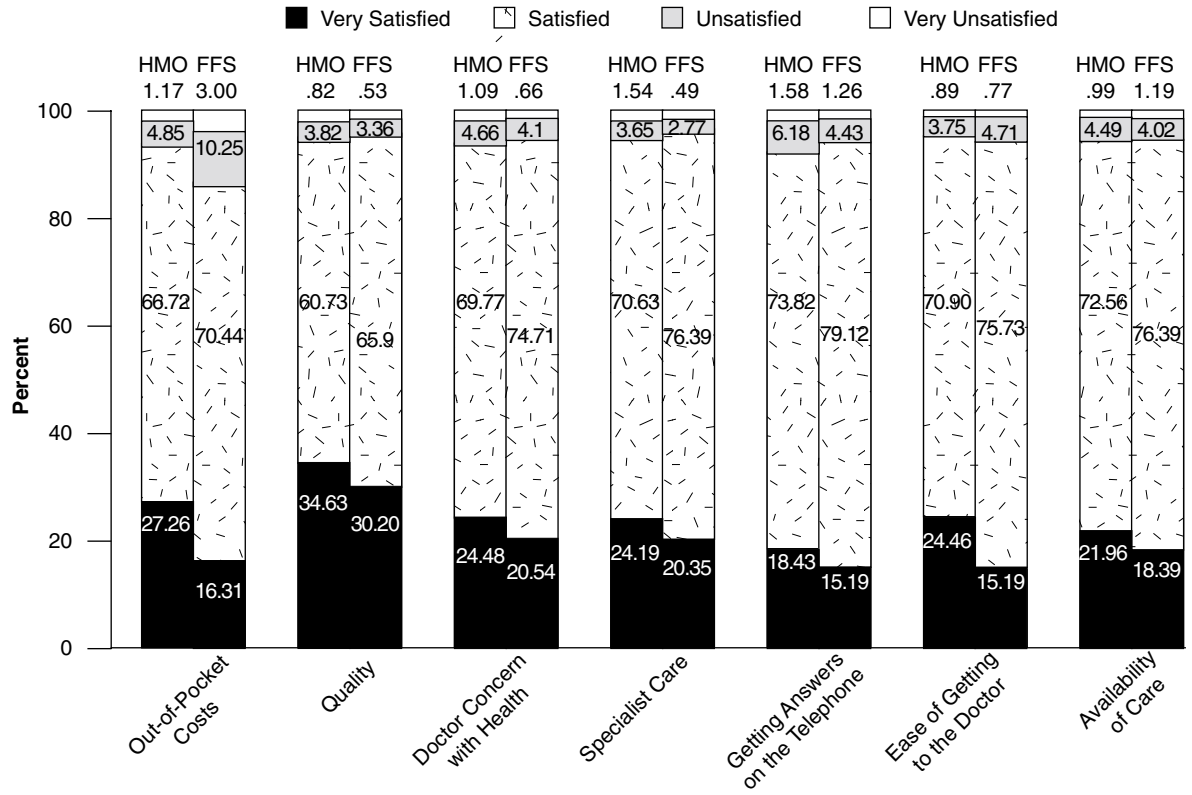


NOTES: Enrollment in each sector grew in this decade. Medicare enrollment increased rapidly in most of the 1990s, but has declined slightly since then. Medicare enrollment numbers are for December of the preceding year, except in 1999, when January 1999 data are used. Non-Medicare numbers are Interstudy January numbers, less Medicare numbers.

SOURCES: Interstudy, Competitive Edge, 1999; Medicare Managed Care Plans: Data from Monthly Summary Plans.

Figure 18

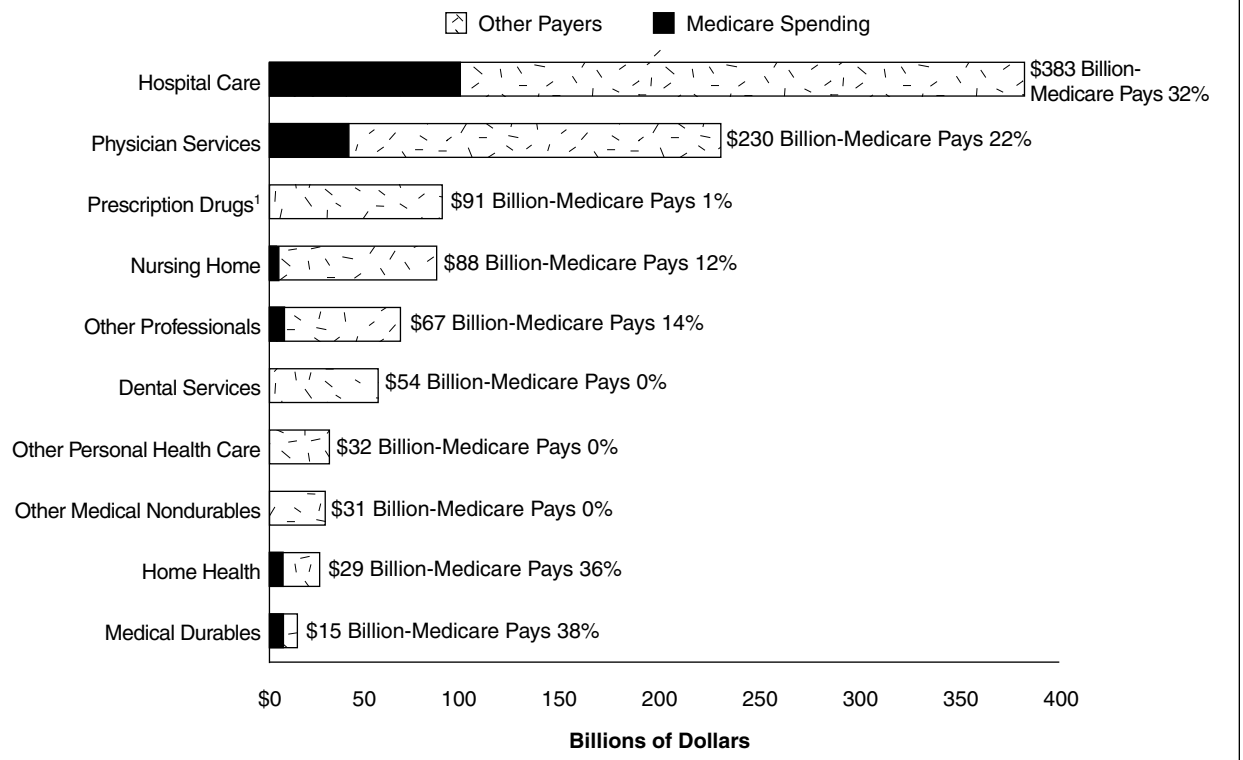
Beneficiary Attitudes Towards Health Maintenance Organizations (HMO) and Fee-for-Service (FFS): 1998



SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data from the Medicare Current Beneficiary Survey, 1998.

Figure 19

National Personal Health Expenditures, by Type of Service and Percent Medicare Paid: 1998



[1] Medicare payments are from managed care plans only, since fee-for-service Medicare does not generally cover outpatient prescription drugs.

NOTE: Total national personal health spending in 1998 was $1 trillion; Medicare accounted for 21 percent.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the National Health Statistics Group, 2000.

Medicaid Spending: A Brief History

John D. Klemm, Ph.D.

Medicaid spending growth has varied greatly over time. This article uses financial and statistical data to trace the history of Medicaid spending in relation to some of the major factors that have influenced its growth over the years. Periods of varying growth are divided into eight "eras," ranging from program startup in 1966 through the post-welfare reform period. Average expenditure and enrollee growth for each era are presented and briefly discussed. Finally, some factors are mentioned that are likely to affect future growth in the Medicaid program.

INTRODUCTION

From less than $1 billion in 1966, Medicaid has grown to a program whose expenditures are expected to top $200 billion in fiscal year (FY) 2000 (Health Care Financing Administration, 2000). During the same period, enrollment[1] has increased from 4 million to 33 million, and per-enrollee spending from less than $200 to more than $6,000. Medicaid spent about $4 per U.S. resident in 1966 and will spend nearly $750 per resident this year. This article reviews the history of Medicaid spending in relation to major events that have driven its growth in various "eras." The approach used is adapted from that found in Muse et al. (1985). The need for brevity necessitates omitting mention of many important aspects of Medicaid's history, some of which are discussed elsewhere in this issue of the *Review*. Two excellent sources of pertinent information on factors affecting Medicaid spending over the years are Congressional Research Service (1993) and Coughlin et al. (1994).

[1] Throughout this article, enrollment is measured by means of full-year-equivalent enrollees, or "person-years."

The author is with the Offic of the Actuary, Health Care Financing Administration (HCFA). The views expressed are those of the author and do not necessarily reflect the views of HCFA.

DATA SOURCES

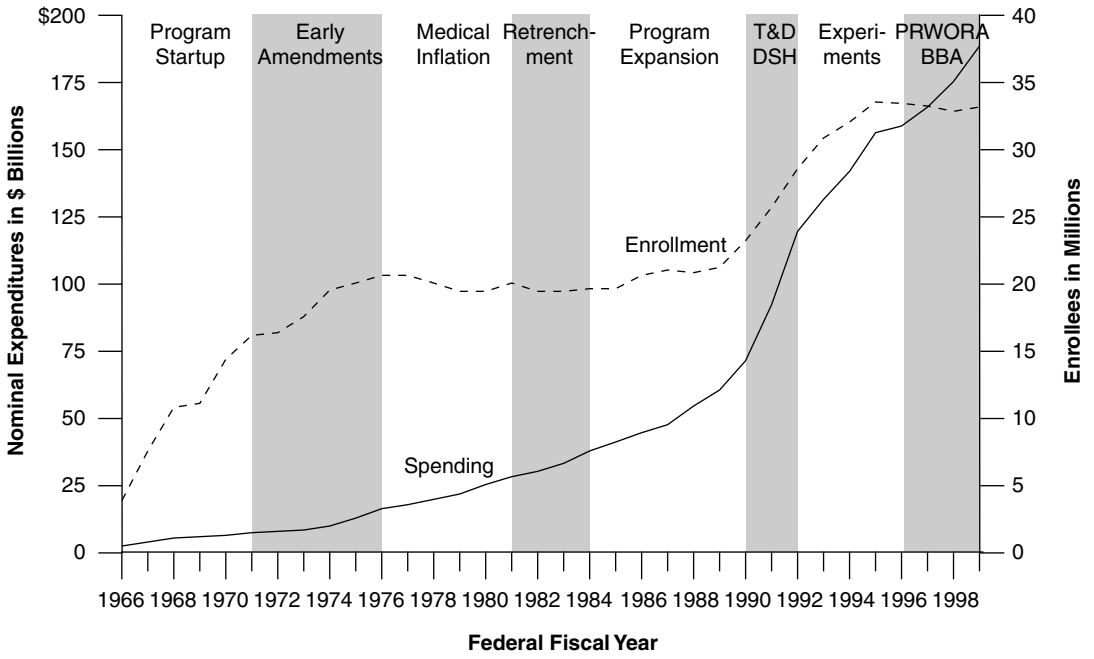
Expenditures in this article have been derived from Medicaid Financial Management Reports (Form HCFA-64 and its predecessors). These forms have been in use since the inception of the Medicaid program and represent the most complete and accurate source of information on Medicaid spending. Expenditures are on a total computable cost basis, (i.e., both Federal and State shares are included) and include benefits and administrative costs.

Enrollment data presented here are taken from annual Medicaid Statistical Reports (Form HCFA-2082) for the period 1975-1998. Earlier data on Medicaid enrollment are derived from information found in Institute for Medicaid Management, (1978) and internal HCFA documents. Enrollee data have been adjusted to a full-year-equivalent (person-year) basis, which takes into account the number of months a person is enrolled during the year (e.g., one person enrolled for 6 months is counted as one-half a person-year.) Since many persons are enrolled for less than the full year, the person-year measure is smaller than measures based on unduplicated counts of individuals ever enrolled during the year (called "eligibles" in Form HCFA-2082).

All years cited refer to the Federal FY as currently defined (October 1 – September 30), and all data have been converted to this basis.

Figure 1

Medicaid Expenditures and Enrollment 1966-1999



NOTES: T&D are taxes and donations. PRWORA is Personal Responsibility and Work Opportunity Reconciliation Act of 1996. BBA is Balanced Budget Act of 1997. Data prior to 1977 have been adjusted to new fiscal year basis (October 1 - September 30). Spending includes benefits and administrative costs, Federal and State shares. Enrollment counts are full-year equivalents and have been estimated from counts of persons served for fiscal years prior to 1990. Data do not include State Children's Health Insurance Program.

SOURCES: Expenditures: Medicaid Financial Management Reports (HCFA-64 and predecessors.) Enrollment: 1966-1974, (Institute for Medicaid Management, 1978); 1975-1998, Medicaid Statistical Reports (HCFA-2082); 1999 projection (Health Care Financing Administration, 2000).

ERAS OF MEDICAID SPENDING HISTORY

As Figure 1 demonstrates, Medicaid spending over the years has followed a typical "exponential" growth pattern, with periods of both faster and slower growth relative to the long-term trend. Following Muse et al. (1985) these periods of varying growth have been divided into "eras," which are briefly discussed. Components of growth rates during these eras are summarized in Table 1.

Program Startup (1966-1971)

The growth of Medicaid during the first 6 years of its existence is typical of most State-based programs at their inception. A number of States implemented programs immediately while others needed several years to get underway. By 1971, annual spending had reached $6.5 billion, and enrollment had topped 16 million. Initial projections of Medicaid forecast less than one-half of this spending level, primarily because analysts greatly underestimated the extent to which States would offer coverage of optional eligibility groups—especially the medically needy—and optional services. Enrollment growth also greatly exceeded original expectations.

As shown in Table 1, expenditures increased by more than one-half, on average, each year during the startup period, while enrollment grew at an average annual rate of nearly one-third, reaching by 1971 almost one-half of what it would be at

Table 1

Medicaid Expenditure Growth, by Era

Era	Description	Annual Compound Rate of Growth			
		Total Expenditures	Enrollees	Price Inflation[1]	Growth in Expenditures per Enrollee in Excess of Price Inflation
		Percent			
1966-1971	Program Startup	52.3	32.2	4.0	10.7
1972-1976	Early Amendments	17.9	4.9	6.5	5.5
1977-1981	Medical Inflation	14.8	-0.7	8.4	6.7
1982-1984	Retrenchment	7.8	-0.3	4.5	3.4
1985-1990	Program Expansion	11.8	2.5	3.8	5.2
1991-1992	Taxes and Donations, DSH	27.3	12.2	3.4	9.7
1993-1996	Experimentation	7.9	3.6	2.2	1.9
1997-1999[2]	PRWORA, BBA	5.6	-0.4	1.6	4.4

[1] Measured by the gross national product implicit price deflator.

[2] Statistics for 1997-1999 do not include State Children's Health Insurance Program.

NOTES: DSH is disproportionate share hospital. PRWORA is Personal Responsibility and Work Opportunity Reconciliation Act of 1996. BBA is Balanced Budget Act of 1997.

SOURCES: Expenditures: Medicaid Financial Management Reports (HCFA-64 and predecessors). Enrollment: 1966-1974 (Institute for Medicaid Management, 1978); 1975-1998 Medicaid Statistical Reports (HCFA-2082); 1999 projections (Health Care Financing Administration, 2000).

the end of the century. Moreover, the rapid growth in covered services resulted in per-enrollee growth that exceeded economywide inflation[2] by nearly 11 percentage points.

Early Amendments (1972-1976)

The next 5 years of Medicaid's history were heavily influenced by major amendments to the Social Security Act (SSA) that were passed by Congress in late 1971 and 1972. The 1972 amendments created the Supplemental Security Income (SSI) program, which federalized existing State cash assistance programs for aged and disabled persons. Nearly all beneficiaries of SSI also receive Medicaid coverage, and the outreach efforts undertaken with the implementation of SSI resulted in significant increases in enrollment among the aged and disabled in Medicaid, averaging nearly 8 percent per year during the period.

The 1971-1972 amendments also added as optional Medicaid covered services intermediate care facilities for the mentally retarded (ICF/MR) and inpatient psychiatric services for beneficiaries under age 22. Residents of these facilities, and the disabled in general, are among the most expensive groups in Medicaid.

Taken together, the 1971-1972 amendments contributed to total expenditure growth averaging 18 percent per year during the 1972-1976 period. Driven by the growth in enrollment of persons with disabilities, total Medicaid enrollment grew at an average rate of almost 5 percent per year, and by 1976 it had reached 20.7 million, a level from which it would not vary by more than a few percent for the next decade.

Medical Inflation (1977-1981)

The period of the late 1970s was marked by sharp increases in economywide inflation and even higher increases in medical prices. General inflation rose at an annual average of 8.4 percent during the 1977-1981 period, peaking at nearly 11 percent in 1980. At the same time, there were no significant legislative expansions of Medicaid eligibility or services during this period, and welfare caseloads were stable or declining. Although Medicaid enrollment actually declined by an average of 0.7

[2] Throughout this article, inflation is measured by the gross domestic product implicit price deflator.

percent per year between 1976 and 1981, annual Medicaid expenditure growth averaged nearly 15 percent.

Retrenchment (1982-1984)

The tremendous growth of the previous decade led Congress and the Reagan Administration to consider ways to reign in Medicaid spending. Administration attempts to place caps on the program failed to pass Congress. However, in the Omnibus Budget Reconciliation Act of 1981 (OBRA-81), Congress did institute a 3-year reduction in Federal financial participation, cutting Federal matching rates by 3.0, 4.0, and 4.5 percentage points in FYs 1982, 1983, and 1984, respectively, for States whose growth exceeded certain targets. OBRA-81 also reduced eligibility for welfare benefits, thus making it harder for poor families to qualify for Medicaid.

To help States cope with reductions in Federal support, Congress enacted a number of flexibility provisions, which broadened State options for providing and reimbursing Medicaid benefits, as well as State authority to limit coverage under medically needy programs. In response, many States began to experiment with alternative delivery and reimbursement systems, such as health maintenance organizations (HMOs) and other capitated programs, home-and-community-based waiver programs, and prospective hospital payment. The focus in Medicaid began to change from merely paying claims to managing services and the cost of care as well. As a result of these changes and a drop in inflation pressures (general price increases averaged about 4.5 percent annually, about one-half the rate of the previous era) Medicaid expenditures grew at an annual average rate of less than 8 percent between 1981 and 1984, while Medicaid enrollment remained stable with an annual average of just under 20 million.

Program Expansion (1985-1990)

With continuing improvements in the economy and concern among policymakers that OBRA-81 may have spawned program contractions that were too harsh, Congress embarked in 1984 on a series of Medicaid expansions that continued each year through the end of the decade. The expansions affected nearly the entire spectrum of Medicaid enrollees from infants, children, and pregnant women to low-income Medicare beneficiaries, and other aged and disabled enrollees. Initially, States were offered options to expand coverage of these groups, but ultimately most of the options were converted by subsequent legislation into mandates, most notably in the Medicare Catastrophic Coverage Act of 1988 (MCCA). It was hoped that the increase in Medicare coverage of elderly and disabled persons under MCCA would help to offset part of the increased cost of the Medicaid mandates included in the bill. However, the Medicare provisions of the MCCA were repealed within a year, before any Medicaid savings impact could be realized.

Historically, Medicaid eligibility for low-income families had been linked to receipt of cash assistance under Aid to Families with Dependent Children (AFDC). The legislation of this era began to weaken this link by specifying eligibility criteria based on income in relation to Federal poverty guidelines. For infants, children, and pregnant women, this legislation introduced income-eligibility levels that were significantly higher than most States' AFDC pay-

ment levels and that were, unlike AFDC levels, indexed to the cost of living. For the low-income aged and disabled, similar poverty-based income thresholds were put in place, with benefits ranging from the full Medicaid package (which has remained optional with States) to coverage of just Medicare premiums and/or cost sharing (mandatory).

Besides these basic eligibility expansions, the 1984-1990 period saw the enactment of many other pieces of legislation, too numerous to mention here, that affected Medicaid eligibility, coverage, and reimbursement. A comprehensive treatment of these can be found in Congressional Research Service (1993).

Many of the expansions introduced between 1984 and 1990 were subject to delayed effective dates or phase-in provisions. (Coverage of children below the poverty level, for example, is still phasing in and will not be complete until 2002.) Thus, the full effect of this era's expansions was not felt during the period. Average annual caseload growth, which turned positive again at 2.5 percent per year between 1984 and 1990, jumped to over 12 percent in the following 2 years and continued to increase steadily through the mid 1990s (Figure 1). There were similar delayed impacts on Medicaid expenditure growth, which increased from the previous 3-year period to an average of 11.8 percent per year during 1984-1990, but the stage had been set for even greater growth in the 2 years that followed.

Taxes and Donations and DSH (1991-1992)

Perhaps no era in Medicaid's history has presented more dilemmas for policymakers, budget officials, and estimators than the short period from 1991 to 1992. The mandates of the previous era, the recession, and other factors all combined to put pressure on already strained State budgets, most of which were running deficits by 1991 or 1992. Increasing Medicaid caseloads (average annual growth of 12 percent) and mounting expenditures prompted some States to turn to alternative financing mechanisms, which relied on disproportionate share hospital (DSH) payments, combined with the use of provider donations or provider-specific taxes as sources of the State share of Medicaid spending.

Medicaid DSH payments, which were designed to help hospitals with a high proportion of low-income and Medicaid patients defray the impact of low reimbursements and uncompensated care, were required by law and, more importantly, not subject to the Federal limits that applied to all other types of Medicaid reimbursement. Thus a State could, if it wished to do so, increase DSH payments to a provider to any level it might choose, recoup the increased payment through a donation from or tax on that provider, and thereby receive essentially unlimited Federal matching funds with little or no increase in net State spending. By 1992, DSH payments had grown to more than $17 billion, or more than 15 percent of total Medicaid spending, and provider tax and donation programs were accounting for about $8 billion in State revenues (Coughlin et al., 1994). More than 30 States had or were planning to put provider tax or donation programs in place.

Concern over State efforts to shift costs to the Federal Government, and a desire to resolve the disputes that had arisen over the Administration's attempts to impose regulatory restrictions on tax and donation programs, led Congress in November 1991 to enact Public Law 102-234, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. This leg-

islation outlawed the use of most provider donations and restricted provider tax programs to those that were "broad based" and did not hold providers "harmless" for their tax payments. Moreover, it placed a statutory aggregate cap on DSH payments at 12 percent of Medicaid spending.

Medicaid spending growth, which averaged over 27 percent per year between 1990 and 1992, slowed considerably in the years following the enactment of Public Law 102-234, although DSH payments remain a significant share of total Medicaid spending.

Experimentation and Reforms (1993-1996)

The years that followed the cost explosion of the early 1990s saw the growth of a number of Medicaid reform efforts and experiments on the part of States. These included increased use of managed care and statewide health reform demonstrations under Section 1115 of the Social Security Act. By the end of 1996, more than 24 States, accounting for over 60 percent of Medicaid spending, had demonstration projects that were either approved or pending. This period also saw an improving economy, along with moderating price inflation (just 2.2 percent per year) and decelerating Medicaid caseload growth (averaging 3.6 percent, or about 30 percent of the previous era). Overall, Medicaid expenditure growth averaged less than 8 percent per year.

The slowdown in spending growth, however, did not come soon enough to deter congressional proposals to convert Medicaid into a block grant program. In 1995, Congress considered establishing the "Medigrant" program, which would have ended the Federal Medicaid entitlement and capped Federal matching funds. Though this provision was not adopted, the prospect of a capped program led States to accelerate spending in FY 1995, which was to be the base year for calculating the block grants (U.S. General Accounting Office, 1997). The resulting increase in 1995 expenditures contributed to a growth rate of less than 2 percent in 1996, the lowest one-year growth rate in Medicaid's history.

Welfare Reform and the Balanced Budget Act (1997-1999)

In 1996 and 1997, Congress passed two pieces of legislation that had significant impact on Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (more informally known as "welfare reform") effectively decoupled Medicaid from cash assistance for low-income families by replacing AFDC with a block grant program known as Temporary Assistance for Needy Families. Families meeting the requirements for assistance under the old AFDC rules continued to be eligible for Medicaid, although there is evidence that many such families did not retain their Medicaid benefits (Garrett and Holahan, 2000).

In 1997, Congress passed the Balanced Budget Act (BBA). Along with other provisions, the BBA gave States the option of setting up Medicaid managed care programs without the waivers that were usually required for such programs. More than one-half of all Medicaid enrollees are currently in some form of managed care program. The BBA also placed further restrictions on DSH spending. However, the most significant provision of the BBA from Medicaid's perspective established the State Children's Health Insurance Program (SCHIP), which authorized nearly $40 billion in Federal funding over 10 years (1998-2007) to provide health coverage to low-income children who did not qualify for Medicaid. States can use SCHIP monies to fund coverage of children through expan-

sions of their Medicaid programs or through separate State programs under a new Title XXI of the Social Security Act. At present, about 40 percent of SCHIP funds are being spent under Medicaid. During FY 1999, more than 2 million children were enrolled under the combined Medicaid and separate SCHIP programs. (Note: The statistics on Medicaid growth in this era do not include the SCHIP program.)

The effects of welfare reform and a thriving economy resulted in 3 straight years of caseload drops in Medicaid (1996-1998), averaging about 0.4 percent per year. At the same time, annual expenditure growth slowed to the lowest levels of any era in the program's history, averaging 5.6 percent in 1997-1999. However, when the decreasing caseloads and general price inflation are factored out, real per capita Medicaid spending growth shows an upsurge since 1996, averaging 4.4 percent compared with less than 2 percent in the previous era (Table 1).

FUTURE TRENDS

As this article shows, the factors that have driven Medicaid spending over the years have varied greatly from one era to the next, resulting in extreme variation in spending growth over time. This variation can generally be expected to continue into the future as new factors come into play. Factors that are likely to figure prominently in Medicaid's future growth include the following:

- The cost of long-term care. Long-term care expenditures in Medicaid (institutional and community-based services) have steadily decreased as a share of total spending over the last 10 years or so—from about 45 percent in the late 1980s to 35 percent today—but can be expected to increase again as the baby boom generation ages.
- The cost of prescription drugs, which averaged 15 percent annual growth during the most recent era and is approaching 10 percent of total Medicaid spending. These costs, like those of long-term care, can be expected to continue to be a significant factor in Medicaid spending as a result of the aging of baby boomers.
- Managed care. The option to provide Medicaid coverage through HMOs and other types of prepaid health plans without a waiver is likely to result in even greater use of managed care in the future. Premiums for these plans currently account for about 15 percent of Medicaid spending and could exceed 20 percent within a few more years if present trends continue.
- Medicaid "maximization." Federal matching programs have always been popular with States; other things being equal, States would rather invest one dollar where it will do two dollar's worth of good. The availability of Federal Medicaid matching has thus led States over the years to adopt innovative strategies designed to obtain the greatest possible Federal funds. This was most noticeable during the taxes and donations and DSH era. Opportunities for maximization are likely to present themselves in the future and could again result in a sudden and unpredictable escalation of Medicaid spending.

Accounting for these and other factors will present a challenge to policymakers and estimators of Medicaid as they attempt to chart the course of the program into the 21st century.

ACKNOWLEDGMENTS

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Nursing Home Initiative

Jan Shankroff, Patricia Miller, Marvin Feuerberg, and Edward Mortimore

Currently, 1.6 million elderly and disabled people receive care in about 17,000 nursing homes across the United States. In 1987, Congress passed major nursing home reforms that defined the role of the State survey and certification process in determining the compliance of nursing homes with Federal standards. In 1998, the President announced new steps to increase Federal oversight of nursing homes' performance, including enhanced monitoring of poorly performing homes, collection of new fines from non-compliant homes, and an increased focus on special care areas such as nutrition, pressure sores, and abuse. HCFA responded with the Nursing Home Initiative (NHI), which was intended to improve the quality of care for nursing home residents. Many of the new activities from the NHI have already been implemented, but it will take more time before we have all of them fully in operation.

INTRODUCTION

HCFA is responsible for the survey and certification program, which ensures that institutions providing health care services to Medicare and Medicaid beneficiaries meet Federal health, safety, and quality standards. HCFA contracts with survey agencies in each State to perform initial inspections of providers who request participation in the Medicare program, annual recertification inspections of nursing homes, and periodic recertification inspections of other health care providers.

The authors are with the Center for Medicaid and State Operations, Health Care Financing Administration (HCFA). The views expressed in this article are those of the authors and do not necessarily reflect the views of HCFA.

One of the major focuses of the survey and certification program is the quality of care provided to nursing home residents. Currently 1.6 million elderly and disabled people receive care in about 17,000 nursing homes across the United States.

ADDRESSING NURSING HOME QUALITY

In response to concerns about the quality of care provided by nursing homes, Congress passed major nursing home reforms in the Omnibus Budget Reconciliation Act (OBRA) of 1987. OBRA 1987 defined the role of the State survey and certification process in determining the compliance of nursing homes with Federal standards. This act also adopted new enforcement procedures, including intermediate remedies, sanctions, and decertification procedures for facilities failing to meet Federal standards.

The 1996 Appropriations Act required HCFA to study and report to Congress on the effectiveness of the current system of survey and certification in nursing homes nationally. HCFA's report was released in July 1998 and concluded that, while some improvement in resident outcomes had been shown, such as in restraint reduction, we needed to do more to improve resident care. On July 21, 1998, the President announced new steps to increase Federal oversight of nursing homes' performance, including enhanced monitoring of poorly performing homes, collection of new fines from non-compliant ones, and an increased focus on special care areas such as nutrition, pressure sores, and abuse.

HCFA responded to the President's announcement with the NHI, which was intended to improve the quality of care nursing home residents receive through new and enhanced Federal and State monitoring activities, as well as imposition of swift and certain sanctions when inadequate care is identified. Some of these new activities include:

- Focusing on preventing bedsores, malnutrition, and resident abuse through increasing the survey sample size of residents, ensuring that facilities have an abuse prevention system, placing a repository of best practice guidelines for at-risk residents on HCFA's website, and launching related educational campaigns.
- Staggering or otherwise varying the scheduling of surveys to reduce the predictability of surveyor visits and requiring that at least 10 percent of surveys be conducted on weekends, in early morning, and in the evening, when quality, safety, and staffing problems often occur.
- Taking faster action to sanction a facility when it has serious non-compliance problems, when it has a history of termination from our programs, or any other time when HCFA or the State believes immediate action is warranted without giving the facility an opportunity to correct its problems before imposing sanctions.
- Inspecting problem facilities twice as often so that persistent problems can be addressed quickly with no decrease in inspections of other facilities.
- Collecting fines of up to $10,000 from facilities when single deficient practices have been found or deficient events have occurred.
- Requiring that complaints alleging harm to residents be investigated within 10 days.
- Posting survey results on the Internet.

Many of these new activities have already begun, but it will take more time to have all of them fully implemented.

LOOKING AHEAD

During summer 2000, HCFA released two Reports to Congress that provided additional information related to the NHI. The first Report, entitled "Appropriateness of Minimum Staffing Ratios in Nursing Homes," provides findings on the first phase of a study examining nurse and certified nurse assistant staffing. The preliminary findings are that there may be a minimum ratio of nurse or certified nurse assistant hours per resident below which nursing home residents are at risk for quality of care problems. The preliminary minimum ratio for certified nurse assistants is approximately 2.0 hours per day per resident. For total licensed staff, licensed practical nurses and registered nurses combined, the ratio is 1.0 hour per resident per day. In addition, this report discusses a time-motion study approach to set the nurse staffing level. This approach measures the amount of time it takes to perform certain patient care tasks, such as feeding assistance, repositioning, and toileting. This approach determined that the minimal nurse aide time required to provide optimal daily care services to residents is 2.9 hours per resident per day. Phase 2 of this study, which began summer 2000, will refine the estimates developed in Phase 1 and will also determine the financial implications of establishing minimum nurse staffing levels.

The other Report to Congress, "The Interim Report on Nursing Home Quality of Care and Implementation of the Nursing Home Initiative," examines the impact of the NHI on the quality of care and quality

of life of nursing home residents. The findings of this report are limited because this initiative has only been in effect for 2 years. The preliminary findings show that the number of off-hours surveys conducted by State survey agencies has greatly increased, and State surveyors are citing more problems in nursing homes; however, it is too early to understand whether there actually are more problems occurring than in the past. This report will be produced annually.

HCFA recognizes the need, and will continue to work, to strengthen consistency in the survey process and interactions between HCFA regional offices and State survey agencies. The need for additional consistency was recognized early in the implementation of the NHI, and in the latter part of 1999 the NHI entered a new phase with the goal of achieving consistency and accountability. This phase will focus on training, tools, evaluation, and data.

- Training initiatives include developing and requiring continuing education for surveyors, developing and instituting training to bring consistency to how survey findings are categorized, and requiring the recertification of surveyors on a regular basis.
- Tools initiatives include developing guidance concerning the classification of individual deficiencies, the examination of the use of available remedies, and the need for additional authorities.
- Evaluation initiatives include the implementation of Standards of Performance for State Survey Agencies, which will provide a consistent base for evaluating and comparing the performance across States.
- Data initiatives will allow greater linkages between data sources, more timely access to data, and easier conversion to information for public use.

Although some of these activities are not core elements of the NHI, we believe that their effect on our ability to monitor and implement the initiative will prove important.

HCFA will continue to strengthen the Federal and State oversight of nursing homes to assure continued improvement in the quality of care and quality of life of the Nation's nursing home residents.

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Medicaid and the HIV/AIDS Epidemic in the United States

T. Randolph Graydon

This article explores the impact on Medicaid costs of new AIDS treatments and other technology advances. Available data on total projected Medicaid expenditures and actual expenditures for antiretroviral drugs are presented. The article further addresses Medicaid State agencies' efforts to assure that Medicaid-eligible persons with AIDS receive quality care, and reviews recent studies on utilization of services among persons with HIV disease.

INTRODUCTION

Since the beginning of the acquired immunodeficiency syndrome (AIDS) epidemic in the early 1980s through December 1999, 733,374 cases of AIDS have been reported to the Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, 1999). Providing for the care for persons living with AIDS presents a remarkable burden to both public and private insurers. Holtgrave and Pinkerton, 1997 estimated that lifetime costs for treatment per patient after the advent of protease inhibitors ranged from $71,143 to $424,763 with the difference primarily based on access to care and whether the real costs were discounted.

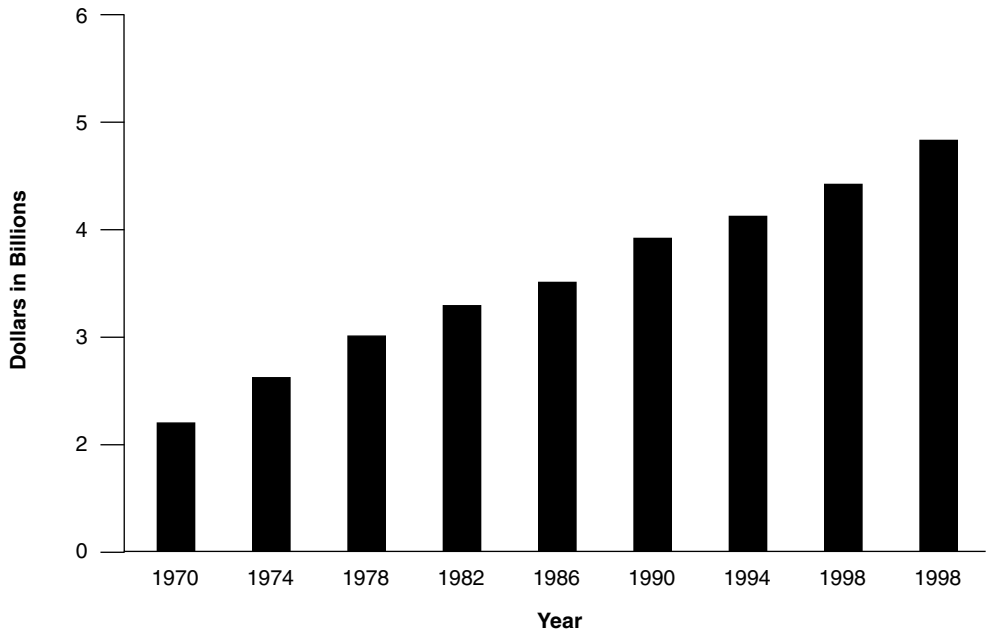
The author is with the Center for Medicaid and State Operations, Health Care Financing Administration (HCFA). The views expressed in this article are those of the author and do not necessarily reflect the views of HCFA.

HCFA'S ROLE IN FINANCING CARE

The Medicaid program is the largest payer in the United States for medical services provided to persons living with AIDS. HCFA estimates that Medicaid pays for the care of 50 percent of all persons living in the United States with AIDS and for 90 percent of the children living with AIDS. (Health Care Financing Administration, 2000a) Medicaid pays for medical and remedial services for individuals with low incomes who are either members of families with children, over the age of 65, disabled, or blind. Other optional categories of eligible persons may be covered at a State's choice (*Federal Register*, 1999). Most persons with AIDS are eligible for Medicaid because their disease has progressed to the point that they meet the Social Security Administration's definition of disability, e.g., the person is no longer able to participate in gainful activity due complications of the disease. Gainful activity is defined as being able to earn at least $700 per month.

HCFA's estimates indicate that the Medicaid program was paying for the care of 5,300 persons living with AIDS in 1986 (Health Care Financing Administration, 1990). Federal and State Medicaid expenditures were estimated in the same document to be $220 million dollars for Federal fiscal year (FFY) 1986. Today, HCFA estimates that the Medicaid program will pay for the services provided to 114,000 persons living

Figure 1
Projected Total State and Federal Medicaid AIDS Costs



NOTE: AIDS is acquired immunodeficiency syndrome.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cist Estimates Group, 2000.

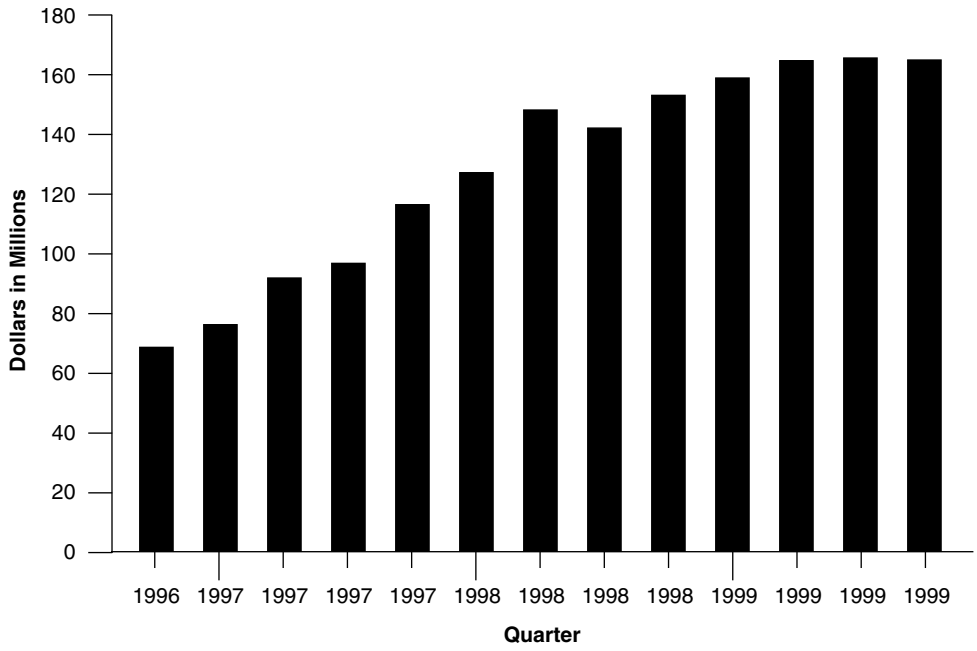
with AIDS in FFY 2000 at a cost of $4.1 billion (Health Care Financing Administration, 1997). Therefore, between 1986 and 2000, the number of persons living with AIDS who are Medicaid beneficiaries has increased by about 215 percent; Medicaid expenditures have increased over 1,860 percent.

HCFA's Office of the Actuary predicts continued growth in Medicaid expenditures for persons living with AIDS. Figure 1 shows the steady increase in the total amount of projected Federal and State Medicaid expenditures for persons living with AIDS between FFY 1994 and 2002 (Health Care Financing Administration, 1997). The remarkable difference in growth in case load to growth in expenditures can be attributed partly to the advances in treatment and monitoring of human immunodeficiency virus (HIV) disease, most significantly, the Food and Drug Administration's (FDA) approval of the first of a then new class of drugs to treat HIV, protease inhibitors (PIs). The FDA approved the first protease inhibitor, Invirase, in December 1995. Since that time, a total of seven protease inhibitors have been approved along with three drugs in a new class of drugs called non-nucleoside reverse transcriptase inhibitors (NNRTI), which are sometimes used in combination with protease inhibitors or in place of them (Department of Health and Human Services/Henry J. Kaiser Family Foundation, 2000b).

Medicaid Coverage of Prescription Drugs

Although coverage of prescription drugs is not required, all States and the District of Columbia currently cover prescription drugs

Figure 2
Medicaid Expenditures for HIV Antiretrovirol Drugs



NOTE: HIV is human immunodeficiency virus.

SOURCE: Health Care Financing Administration, Center for Medicaid and State Operations: Data from the Medicaid Drug Rebate Initiative Data System, 1997.

under their Medicaid programs. However, some States do limit the number of prescription drugs that may be filled in a month and/or the number of refills permitted.

HCFA gave clear direction to State Medicaid agencies in a letter dated June 19, 1996, that States which elect to cover prescription drugs are required to cover all the FDA-approved PIs, and other FDA-approved drugs. Most combination antiretroviral regimens cost between $12,000 and $15,000 per patient per year, however, with many patients being placed on regimens of four and five drugs, the cost can grow significantly. Figure 2 shows the increase in Medicaid expenditures for HIV antiretroviral drugs from the last quarter of FY 1996 (July, August, and September) and the last quarter of FY 1999 (Health Care Financing Administration, 2000b).

QUALITY OF CARE PROVIDED MEDICAID BENEFICIARIES

States have made efforts to improve the quality of care for Medicaid beneficiaries with AIDS by widely distributing treatment guidelines provided by HCFA, and encouraging providers to take advantage of treatment resources provided on the internet. Some States have been aggressive in developing Medicaid waivers that provide services essential to the improvement of the care and quality of life for persons with AIDS. Currently 16 States have home and community-based services waivers that provide services specifically to persons with AIDS; these services are necessary to avoid or minimize costly hospital or nursing facility stays. Services provided may include case management, homemaker

services, home health care services, adult day health care, basic living skills and vocational training, and respite care.

Despite States' efforts to improve the quality of care and the broad package of services that are available to Medicaid beneficiaries with AIDS, early studies indicated that the quality of care being provided to Medicaid beneficiaries is less than optimal. The HIV Cost and Services Utilization Study, a national sample representative of the adult HIV-infected population receiving regular medical care in the 48 contiguous States from early 1996 to early 1998, found disparities between the quality of care provided to Medicaid beneficiaries and persons having other types of insurance coverage. The study measured quality using six measures: (1) fewer than two office or outpatient visits in 6 months, (2) emergency department visit without an associated hospitalization in 6 months, (3) hospitalization in 6 months, (4) did not receive PI or NNRTI therapy by December 31, 1996 if recommendations for treatment were met, (5) never received antiretroviral treatment, and (6) did not receive prophylaxis in the last 6 months for pneumocystis carinii, a type of pneumonia to which persons with AIDS are susceptible, if CD4 count was less than 200. (CD4 count is a measure of the health of the immune system. Mean levels in healthy individuals are usually between 800-1050.) Data gathered for the base line of the study showed that Medicaid beneficiaries faired worse on all six measures than did persons with private insurance, and worse on four of the measures than Medicare beneficiaries. Not surprisingly, Medicare beneficiaries had more emergency department visits and more hospitalizations. Overall, the only group that received poorer care than Medicaid beneficiaries were those without any insurance.

However, States' efforts to improve quality are showing results. Encouragingly in the followup interviews conducted in 1998, Medicaid showed improvement in the quality of care provided as measured in all six of the indicators of quality of care. Most notable was the increase in the use of PIs and NNRTIs which rose from 53 percent to 81 percent (Shapiro et al., 1999).

CHANGING DEMOGRAPHICS OF HIV DISEASE

Over time, the demographic characteristics of the HIV epidemic have changed, as has the natural history of HIV infection among persons receiving appropriate treatment. HIV/AIDS in the developed world has been transformed from a rapidly fatal infection diagnosed at a late stage of the disease to a chronic progressive illness that affords many years of productive life under complex treatment regimens (Department of Health and Human Services, 2000a). With this change in the natural history of the disease, the categorical nature of the Medicaid program has rendered many persons receiving proper treatment unable to qualify for Medicaid because they don't meet the definition of disability. The majority of these individuals who are uninsured receive their care through the Ryan White CARE Act programs which base eligibility on HIV positive status. As persons with HIV disease live longer, the demands on Ryan White funding have increased.

Medicaid's Response to the Changing Demographics

To address the issue of the Medicaid program not being able to serve persons with chronic manageable diseases, a number of actions have taken place at both the Federal and State levels.

- The State of Maine has submitted and gained HCFA approval for a demonstration waiver that permits Medicaid coverage to be extended to persons with HIV disease prior to becoming disabled. The theory of the demonstration is that early treatment will delay the onset of AIDS and thus offset the cost of the early treatment making the demonstration budget neutral to the Medicaid program. A number of other States are also pursuing similar waiver authority. Early treatment of HIV disease is currently recommended by the DHHS/Kaiser Family Foundation sponsored Panel on Clinical Practices for Treatment of HIV Disease (Department of Health and Human Services, 2000b).
- In addition, Under the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999, the Congress has provided grant money for HCFA to award States to evaluate the impact of early interventions in HIV and other diseases. At the time of this writing, one State has been approved for a grant to provide coverage for persons with HIV disease that do not meet the Social Security Administrations' definition of disability. HCFA plans to issue a second request for proposals prior to the end of calendar year 2000. TWWIIA has also increased the income levels States may elect to allow persons with disabilities to return to work without losing their Medicaid coverage.

HCFA'S MATERNAL HIV CONSUMER INFORMATION PROJECT

Finally, the Medicaid program has also played a strong role in preventing mother-to-child transmission of HIV disease. After the National Institutes of Health's Clinical trial 076 established that mother-to-child transmission of HIV could be reduced by 75 percent using a regimen of zidovudine (commonly called AZT), HCFA launched a pilot project in four States to inform women of child-bearing age of the importance of pregnant women being tested for HIV. The campaign is known as the Maternal HIV Consumer Information Program. It also stresses that Medicaid pays for HIV counseling and testing for Medicaid-eligible pregnant women. The project brings together the Medicaid Agency, the State Health Department, and other relevant community resources. HCFA provides informational brochures about prevention of mother-to-child HIV transmission as well as a video at no charge for the State's campaign. As of August 2000, HCFA had met its National Performance Review Goal to have a consumer information campaign on mother-to-child HIV transmission in all 50 States and Puerto Rico. All States do not use the HCFA materials, but all States do have a campaign in place. HCFA now offers campaign print materials in 14 different languages, and has in production a new video in Spanish and English with accompanying educational materials for physicians and their patients.

CONCLUSION

The Medicaid program is the largest payer of health care services for persons living with AIDS in the United States. Although questions have been raised about the quality of care being provided to Medicaid beneficiaries with HIV disease, more recent studies reflect a significant improvement in quality of care as measured by the indicators used in the study. State Medicaid agencies are working with HCFA to continue the trend in improving care to persons with HIV disease. HCFA will continue to work with States and other Federal agencies to improve the delivery of services to persons with HIV disease in the most effective manner. HCFA is also

working with States to implement new programs designed to address the chronic care needs of persons with AIDS who are benefiting from new, more effective treatment regimens.

HCFA has a particular interest in prevention of childhood AIDS, as the payer of care for 90 percent of the children with AIDS. With the majority of childhood AIDS due to mother-to-child HIV transmission, HCFA is taking a leadership role in prevention of childhood AIDS by establishing and promoting its Maternal HIV Consumer Information Program.

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Home and Community-Based Services Waivers

Mary Jean Duckett, M.S.P., and Mary R. Guy, M.S.Ed., M.S.W.

The history and current status of the Medicaid Home and Community-Based Services Waiver Program are presented. The article discusses the States' role in developing and implementing creative alternatives to institutional care for individuals who are Medicaid eligible. Also described are services that may be provided under the waiver program and populations served.

BACKGROUND

The growth of home and community-based services (HCBS) under Medicaid can be traced to the early 1980s when it was found that:

- A disproportionate percentage of Medicaid resources were being used for institutional long-term care (Davidson, 1980; Grannemann and Pauly, 1983; Holahan, 1975; Spiegel and Podair, 1975).
- Several studies documented that at least one-third of persons residing in nursing facilities that were Medicaid funded would have been capable of living at home or in community residential settings if additional supportive services were available (Fox and Clauser, 1980; Kraus, et al., 1978; Pegels, 1980; Weissert, 1986).
- A contributing cause of unnecessary use of Medicaid institutional care was an "institutional bias" in the Medicaid benefit and eligibility structure (Grannemann and Pauly, 1983; Holahan, 1975; Leonard, Brust, and Choi, 1989; Weissert and Scanlon, 1985).
- Residents in both nursing facilities and intermediate care facilities for the mentally retarded frequently reported an unsatisfactory quality of life (de Silva and Faflak, 1976; Gardner, 1977; Lakin and Hall, 1990; Scheerenberger, 1976).
- A number of court cases resulted in court orders to deinstitutionalize persons with developmental disabilities.[1]

The HCBS waiver program was established by Section 2176 of the Omnibus Budget Reconciliation Act of 1981 and was incorporated into the Social Security Act (the Act) at Section 1915(c). Under the HCBS waiver program, States can elect to furnish under Medicaid, as an alternative to institutional care, a broad array of services (excluding room and board) that are not otherwise covered under the Medicaid program. Passage of this statute represented a first step towards recognizing that many individuals at risk of institutionalization can be supported in their homes and communities, thereby preserving their independence and bonds to family and friends, at a cost not higher than institutional care (Health Care Financing Administration, 1996).

The Act lists seven specific services that may be provided under the HCBS waiver program. They are:

- Case management services.
- Homemaker services.
- Home health aide services.
- Personal care services.
- Adult day health care services.
- Habilitation services.

The authors are with the Center for Medicaid and State Operations, Health Care Financing Administration (HCFA). The views expressed in this article are those of the authors and do not necessarily reflect the views of HCFA.

[1] *Kentucky Association for Retarded Citizens, Inc.* v. *Connecticut, 1982; Homeward Bound, Inc.* v. *Hissom Memorial Center, 1987; Garrity* v. *Gallen, 1981; Lynch* v. *Maher, 1981; Halderman* v. *Pennhurst State School and Hospital, 1981.*

- Respite care services (Health Care Financing Administration, 1996).

Although not specified in the Act, other services may be provided at the request of the State if approved by HCFA. Such services must be cost effective and necessary for waiver participants to avoid institutionalization. For example, these services may include transportation, in-home support services, meal services, special communication services, minor home modifications, and adult day care (Health Care Financing Administration, 1996). HCBS waiver services may be provided to individuals who are elderly and disabled, physically disabled, developmentally disabled or mentally retarded, or mentally ill. HCBS waiver services may also be targeted to individuals with a specific illness or condition, such as children who are technology-dependent or individuals with AIDS (Health Care Financing Administration, 1996). In the absence of the HCBS waiver these individuals would require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

States have a great deal of flexibility in designing their own unique HCBS waiver program(s). This enables a State to identify a specific population and target services to that population to meet the population's unique needs. Each waiver must be reviewed and approved by HCFA.

ADVANTAGES OF HCBS WAIVERS

As previously noted, the HCBS waiver program gives States the flexibility to develop and implement creative alternatives to institutional care for individuals who are Medicaid eligible. This flexibility is advantageous to the States as it allows States to tailor their programs to the specific needs of the populations they wish to serve. For example, under the HCBS waiver a State may:

- Provide services in the home or community as a cost-effective alternative to institutional care.
- Divert or prevent extended institutionalization of individuals.
- Target services to a specific group by waiving Section 1902(a)(10)(B) of the Act which relates to the comparability requirement.
- Limit services to a specific geographic area by waiving Section 1902(a)(1) of the Act which relates to the statewideness requirement.
- Request services not otherwise available under its Medicaid plan.
- Request an exception to the deeming rules under the Social Security Administration's Supplemental Security Income Program, thereby the eligibility determination for an individual in the community on an HCBS waiver is made using institutional versus community deeming rules.

The Medicaid HCBS waivers are an important tool for States to meet the requirements of the Americans with Disabilities Act (ADA) as defined by the U.S. Supreme Court in the *Olmstead* v. *L.C.* decision. In the Olmstead decision, the Court found that "unjustified isolation…is properly regarded as discrimination based on disability" in violation of the provisions of the ADA. The Court affirmed the policy that the ADA supports access to community living for persons with disabilities by obliging States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of the qualified individuals with disabilities." In addition, the Court found that institutionalization severely limits a person's ability to interact with family and friends, to work, and to make a life for himself or herself.

To help States comply with the Court's ruling, HCFA and the Department of Health and Human Services' Office for Civil Rights have begun working with States and the disability community toward the goals of promoting HCBS and honoring individual choice in service provision.

CURRENT STATUS

Since enactment in 1981, the HCBS waiver program has experienced significant growth. Estimated total Medicaid expenditures for the HCBS waiver program for 1998 were over $9 billion for an estimated 606,953 participants (Harrington et al., 1999). States continue to renew existing HCBS waivers, as well as request new HCBS waivers. Presently, there are 250 approved waiver programs operating in 49 States. (Arizona provides similar services under the authority of a section 1115 demonstration waiver rather than a section 1915(c) waiver [Harrington et al., 1999].)

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Health Reform, Year Seven: Observations About Medicaid Managed Care

Clarke Cagey, M.A.

Over the last 7 years, State and Federal policymakers have reformed State medical assistance programs and, in the process, have grappled with goals of both containing program costs and expanding health insurance coverage to the uninsured. Currently, nearly one-quarter of all States have implemented health care reform demonstrations, and this article summarizes trends seen since health care reform began in the 1990s. As well as noting the accomplishments of health care reform through the use of Medicaid managed care, the article speculates, based on recent evidence, about new directions health care reform may take in the future.

INTRODUCTION

Shortly after taking office, President Clinton committed to the Nation's governors that his Administration would work closely with States to test innovative concepts and programs within existing health and welfare demonstration authorities. By August 1993, several policy principles were articulated and were later published in the *Federal Register* (1994). Among the Administration's commitments were: a streamlined process for demonstration waivers pursuant to Section 1115 of the Social Security Act (the act); a willingness to test a broad variety of policy alternatives; and a granting of waivers of provisions of the act for a sufficient duration to test the success of new policy approaches (typically 5 years for statewide health care reform demonstrations). Where appropriate, the Department of Health and Human Services (DHHS) was also committed to seeking statutory changes in recognition of successful aspects of State programs.

Since that time, nearly one-quarter of all the States have sought authority under the auspices of section 1115 to implement reform efforts. While the overarching goals of these States have varied—including cost containment, Medicaid coverage expansions to previously ineligible individuals and, most often, a combination of both—it is important to note at the outset that State health care reform efforts have always, to some degree, been tied to managed care. In every large-scale health care reform demonstration approved by HCFA, managed care has been a mechanism to find savings to redirect in State health care systems.

The Balanced Budget Act (BBA) of 1997 provided a streamlined process for extending health care reform demonstrations for 3 additional years. Most States with approved health care reform demonstrations have opted to avail themselves of this process, which allowed them to keep current managed care contracting arrangements—and other significant changes to their health care delivery systems—in place. As of this writing, several States are in year two of this 3-year extension period, which provides a useful vantage point to summarize existing reform efforts, and make some suppositions regarding future trends in State

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demonstration programs. Managed care, as implemented through other authorities, will be considered as well.

MANAGED CARE AUTHORITIES

There are currently three options that States may use to implement mandatory managed care programs. These are the authorities found in sections 1915(b), 1115, and 1932(a) of the act. Both section 1915(b) program waivers and section 1115 research and demonstration waivers allow States exemption from certain statutory requirements. These waiver authorities, delegated by the Secretary of DHHS to HCFA, allow States to pursue programmatic options not available under the State plan amendment process. A significant recent development stemming from BBA is a State plan amendment (SPA) process under section1932(a), which allows States to implement a significant programmatic feature—mandatory enrollment in managed care—without waiver or demonstration authority.

Waiver and Demonstration Authority

Section 1915(b) waivers—also known as Freedom of Choice waivers—allow States to pursue greater use of managed care delivery systems for Medicaid beneficiaries. Since these waivers are limited to section 1902 provisions of the act, they are more limited in scope and flexibility than 1115 waivers. Specifically, section 1915(b) waivers cannot be used to allow States to: cover nontraditional Medicaid populations; modify Medicaid benefits and cost sharing; restrict access to certain provider types; pay some provider types, such as federally-qualified health centers at rates other than those required by the act; or cover services provided by managed care organizations which do not comply with the requirements of section 1903(m).

Under section 1115, the Secretary of DHHS is granted much broader authority and may waive many of the requirements that are not waivable under section 1915(b). Section 1115 requires that any waiver given under its authority for research and demonstration purposes "…assist in promoting the objectives of the Medicaid statute," as determined by the Secretary. States have used this authority to implement mandatory managed care, while simultaneously implementing the other types of reforms previously noted.

State Plan Amendment Authority

Before the BBA, States could not implement mandatory managed care without approval of a section 1915(b) waiver program or a section 1115 demonstration project. The BBA added a process (1932(a) of the act) through which States may implement mandatory managed care under the SPA process. There is no requirement that such programs demonstrate cost effectiveness or budget neutrality, requirements for 1915(b) waivers and 1115 demonstrations, respectively. While this aspect of section 1932(a) would appear advantageous to State policymakers, there are statutorily-defined restrictions regarding which populations may be included in mandatory managed care (for example, there are prohibitions on including children with special health care needs, dual eligibles, and Native Americans). To date, 10 SPAs have been approved to implement mandatory managed care. The restrictions on populations that may be included—in addition to the familiarity States have with waiver and demonstration programs—likely means that States will not, for the most part, be attempting to transition waiver and demonstration programs into ones authorized by a SPA.

OBSERVATIONS

As some of these demonstrations have now been operational for as long as 7 years in some cases, it is clear that two significant observations may be made about the evolution of Medicaid managed care and the use of section 1115 authority: the focus on large-scale coverage expansions has decreased; at the same time, the interest in tailoring State managed care programs to meet the needs of higher-cost, higher-use populations has increased.

Coverage Expansions

Despite the addition of the 1932(a) SPA process, it is clear that demonstration and waiver authorities continue to be central to State strategies for health care reform. However, it is clear that over time, the nature of State proposals under section 1115 has shifted away from large-scale expansions in coverage and has come to focus increasingly on using managed care while altering payment arrangements or limiting access to certain providers. Furthermore, the expansions that States do propose tend to be linked in some way to Title XXI of the Act, the State Children's Health Insurance Program (SCHIP).

Of the first six demonstrations awarded in the early 1990s, all included significant expansions to groups that previously had not been eligible for Medicaid. Oregon (1993), Hawaii (1993), Kentucky (1993), Rhode Island (1993), Tennessee (1993), and Florida (1994) proposed to expand Medicaid coverage to higher income levels, in some cases adding the uninsured up to 300 percent of the federal poverty level. However, while the Florida and Kentucky demonstrations were never implemented as approved, the uniformity of the States' approach is clear: managed care and new payment arrangements for certain providers are used as a means to find savings to expand health care coverage. The number of additional individuals expected to be covered under these original health care reform efforts was roughly 1.7 million (Rotwein et al., 1995).

The mid- and late-1990s still saw some emphasis placed on expanding coverage. Yet, contrasted with the first 6 demonstrations approved, those that followed expanded coverage in 10 cases out of 15. Perhaps significantly, one of the non-expansion States was a revised proposal that eliminated a previously approved coverage expansion (Kentucky). Also, among those States that did expand coverage, one expansion (New Mexico) was financed entirely with funds from a separate title of the Act—Title XXI—not from savings within Title XIX; it used 1115 authority only to implement an alternative cost-sharing structure. Two other States (Missouri and Wisconsin) have implemented Medicaid expansions for adults, but only in concert with related expansions for children under Title XXI. Factoring out these 3 States, it is noted that only 7 out of the remaining 12 represented the type of coverage expansions seen with the earlier demonstrations.

Thus, it is reasonable to conclude from these data that States are no longer as focused on using section 1115 demonstration authority under Title XIX for significant coverage expansions. As we have seen, comparatively fewer new demonstrations seek to expand coverage; among those that do, they link adult expansions done with 1115 demonstration authority to children covered under Title XXI. These developments support the contention that since the inception of SCHIP in the 1997 BBA, the focus of health care expansions in States shifted to children. Aside from programmatic flexibility, Title XXI offers States an enhanced Federal matching rate for covering low-income children previously cov-

erable only under section 1115 authority. Thus, one can theorize that many future adult expansions using section 1115 demonstration authority will typically be linked to child expansions under SCHIP.

Special Populations, Capitated Programs, and Coverage Expansions

Over the course of the 1990s, States have also moved to incorporate higher-cost, higher-use populations into Medicaid managed care. Generally speaking, States first concentrated upon enrolling individuals eligible for Medicaid by virtue of being eligible for Aid to Families with Dependent Children—or later Temporary Assistance for Needy Families (TANF)—into managed care, whether this enrollment was through waiver or demonstration authority. In recent years, the enrollment into Medicaid managed care of higher-cost, higher-use populations comprised of individuals with more complex medical conditions has been another discernable trend. It is, however, important to remember that while either sections 1115 or 1915(b) authority may be used to enroll higher-cost populations into managed care, the broad scope of section 1115 authority also allows States to expand health insurance coverage to such individuals without reference to the type of delivery system to be used. In recent years, HCFA has observed that both types of State initiatives have become more commonplace.

SSI—Enrollment in Managed Care

One Medicaid-eligible population of significant size, made up of those individuals eligible for Supplemental Security Income (SSI), was traditionally carved out of Medicaid managed care under waiver and demonstration authorities. SSI-eligible adults have functional impairments that prevent them from gainful employment; SSI-eligible children have an impairment or combination of impairments that are considered disabling if it causes marked and severe functional limitations (Social Security Administration, 1997). Given these factors, SSI eligibility is a reasonable indicator of higher—or perhaps less predictable—need for medical services than the TANF population.

Currently, many within the SSI population are included in State Medicaid managed care initiatives. By 1998, nearly 75percent of the States were using either section 1915(b) or section 1115 waiver authority to enroll at least some Medicaid/SSI beneficiaries into Medicaid managed care. The number of individuals served by these programs, 1.6 million, represents nearly one-fourth of Medicaid's non-elderly disabled beneficiaries (Regenstein and Schroer, 1998) and may be expected to climb.

Dually-Entitled—Services in the Community

States are also increasing focus on the frail elderly, many of whom are entitled to both Medicare and Medicaid. The Consolidated Omnibus Budget Reconciliation Act of 1985, authorized the original Program of All-Inclusive Care for the Elderly (PACE) section 1115 demonstration waiver for On Lok Senior Health Services, which served the elderly in San Francisco's Chinatown. Later, the Omnibus Budget Reconciliation Act of 1986 authorized HCFA to conduct a PACE demonstration project to determine whether the model of care developed by On Lok could be replicated across the country.

Most recently, the BBA authorized coverage of PACE under the Medicare program and as a State option under Medicaid. PACE is a prepaid, capitated plan that provides comprehensive health care services

to frail, older adults in the community, who are eligible for nursing home care according to State standards. Services are furnished through an adult day health center, which is staffed and equipped to provide multidisciplinary care, at participants' homes, and at inpatient facilities if warranted by the participant's medical condition. The movement of PACE from demonstration to program status and the widespread State interest that has been expressed in the State option, signals an increased focus on reforming the health care delivery systems that serve the frail elderly.

HIV/AIDs—Coverage Expansion

In addition to initiatives focused on the SSI population and the dually entitled, another trend in 1115 demonstrations has been to use this authority to cover individuals with complex conditions in a fee-for-service environment. For example, in February 2000, Maine received approval to implement a demonstration for individuals living with HIV and/or AIDS up to 300percentof the FPL. The goal of this demonstration is to increase access to highly active retroviral therapy treatment that can delay the onset of disabling illnesses for this population. HCFA anticipates that other States may attempt to replicate such an approach for this population, whether through stand-alone proposals or through amendments to existing demonstrations.

MEDICAID REFORM AND THE FUTURE

Clearly, the Medicaid program continues to evolve as we move into the next century. The 1990s witnessed a significant attempt on the part of States and HCFA to reform this large public insurance program: waiver and demonstration authority would permit the use of managed care and the restructuring of payments to certain providers, and in turn States could expand coverage to the previously uninsured. Currently, it is estimated that over 1 million people have health insurance through these reform efforts that they would otherwise not have.[1] As previously noted, however, over the course of the 1990s, expansions in coverage using demonstration authority decreased, due to the focus on children and enhanced Federal matching funds brought about by the SCHIP program. Accordingly, there is reason to conclude that the new directions taken in State health care reform, using section 1115 authority, will be parent expansions related to child expansions under SCHIP, or will be attempts to either extend fee-for-service or managed care health insurance coverage to additional special populations while addressing their unique health care needs.

What these new directions demonstrate is that State efforts will continue to have a critical role to play in determining the future course of health care policy. Past State efforts to expand health care coverage to additional low-income individuals have made a significant difference to over 1 million individuals previously lacking this coverage. At the same time, we can observe that, as States have adapted to changing conditions, they are sustaining the health care reform agenda by focusing on innovative programs that expand coverage for high-cost populations, integrate services for them more fully, or both; these efforts are in addition to those to expand health care coverage for children.

[1] This number excludes the cases of Missouri, New Mexico, and Wisconsin for reasons discussed earlier. The disparity between this number and the 1.7 million that were anticipated to be covered under the first six demonstrations is in large part due to the fact that Florida Health Security (capped enrollment at 1.1 million) was never implemented.

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Medicaid and the Health of Children

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The Medicaid program has evolved and expanded since its inception in 1965, providing health insurance coverage for ever-increasing numbers of children living in poverty. During the first 35 years of Medicaid, the program has expanded coverage to include preventive services for children, expanded eligibility criteria to include uninsured children not receiving welfare. The Medicaid program has encouraged innovation in the form of managed care and primary care case management. Most recently, the State Children's Health Insurance Program (SCHIP) has given States freedom in providing more children with coverage. Medicaid has had a powerful influence on the health of the Nation's children. Because of Medicaid coverage, fewer children die, and children have less severe illnesses, fewer hospitalizations, fewer emergency department visits, more preventive care, and more immunizations than they would have had they not been insured.

EVOLUTION OF MEDICAID FOR CHILDREN

Since its inception in the 1960s, the Medicaid program has provided health insurance coverage to low-income children and their families. Initially, Medicaid covered only children meeting the requirements of the Aid to Families with Dependent Children (AFDC) program. Since then, Medicaid has steadily evolved and expanded. Some of the major changes included expansion of coverage to new eligibility groups, expansion of services, the introduction of Medicaid managed care, the delinking of Medicaid and welfare and the SCHIP legislation. Today, Medicaid is the major insurer of children, covering 20 percent of children under age 18 and 27 percent of children under age 6 (National Center for Health Statistics, 1999).

ELIGIBILITY EXPANSIONS

During the 1980s, Medicaid rapidly expanded beyond its AFDC base to cover increasing numbers of low-income children and their mothers. The following expansions occurred:

- Deficit Reduction Act of 1984—mandated coverage of all AFDC-eligible children born after September 30, 1983 and extended coverage to AFDC-eligible first-time pregnant women and two-parent families.
- Consolidated Omnibus Budget Reconciliation Act of 1984—extended coverage to all remaining AFDC-eligible pregnant women.
- Omnibus Reconciliation Act of 1986 (OBRA—allowed coverage of pregnant women and children under age 1 up to 100 percent of the Federal poverty level (FPL).
- OBRA 1987—permitted coverage of pregnant women and children under age 1 up to 185 percent of the FPL.
- Medicare Catastrophic Coverage Act of 1988—required coverage of all pregnant women and children under age 1 up to

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100 percent of the FPL, and allowed States the option to extend coverage to families with incomes higher than 185 percent of the FPL.
- OBRA 1989—raised the minimum eligibility requirement to 133 percent of the FPL for pregnant women and children up to age 6.
- OBRA 1990—mandated coverage for children born after September 30, 1983 with family incomes below 100 percent of the FPL.

EXPANSION OF COVERED SERVICES

The most significant addition to the services available to children through Medicaid was the creation of the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in 1967. The goal of this provision was to ensure that Medicaid-eligible children received appropriate primary and preventive care. Accompanying regulations required States to develop periodicity schedules, which specified physical exams, screenings, and laboratory tests be provided to eligible children at each stage of development. Under the OBRA 1989 legislation, many of the provisions embodied in regulation were codified into law. A requirement was also added that States must provide any service that is needed to treat medical conditions identified during EPSDT screenings, whether or not the service is included in the State's Medicaid plan. States were also to establish goals for participation in the EPSDT program, with a goal of 80 percent participation to be achieved by 1995.

MEDICAID WAIVERS AND MANAGED CARE

Medicaid was initially designed to be a program that reimbursed health care providers directly for services rendered to eligible individuals. Persons eligible for Medicaid were free to receive care from any Medicaid-participating provider, who would then bill Medicaid for the cost of care. In 1981, however, Congress created Section 1915(b) of the Social Security Act, allowing States to obtain waivers of the freedom of choice requirement. This allowed States to begin developing Medicaid managed care programs to address problems in access to comprehensive care among low-income children while controlling costs. In the early 1990s, the Clinton Administration pledged to work constructively with States to facilitate testing of new policy approaches to health care through the use of the section 1115 demonstration waiver authority. Since then, 17 States have been granted waivers to operate section 1115 demonstration projects for health care reform. Many of these States expanded coverage to new populations, using the savings from enrollment of Medicaid eligibles into managed care to offset the cost of the reforms. In addition, States wanted to improve access, health status, and utilization of services through the use of innovative managed care delivery systems.

Two major models of Medicaid managed care were developed. Under the primary care case management (PCCM) model, families choose or are assigned a primary care physician who provides health care services and must authorize specialist treatment when needed. Most services continue to be reimbursed directly by Medicaid. Under the capitated managed care model, Medicaid-eligible children are enrolled in managed care plans that receive a fixed Medicaid payment per month for each child for a defined benefit package. Children may receive care only from providers that have contractual relations with their plan. Emergency services and family planning services are among

the exceptions to this requirement. In 1991, 10 percent of Medicaid eligibles nationwide were enrolled in some form of managed care. By 1999, this percentage had grown to 55 percent, of which 42 percent were enrolled in a capitated managed care plan, and 13 percent had a primary care gatekeeper.

DELINKING MEDICAID AND WELFARE

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PROWA) led to the complete delinking of welfare and Medicaid. Under the new law, families meeting the financial criteria for Medicaid coverage are eligible regardless of their welfare status. Because of delinking, many families and children were improperly terminated from Medicaid, resulting in declines in Medicaid enrollment in 1997. Before PROWA, families typically became eligible for Medicaid by participating in AFDC. Since welfare reform, families receiving cash welfare have become a minority among adult and child recipients. States now face the challenge of maintaining Medicaid enrollment without the linkage to cash assistance. A number of States have increased access through eligibility campaigns, aggressive outreach, and simplification of enrollment processes.

NEW ERA FOR MEDICAID—SCHIP

In 1997, in response to declining Medicaid enrollment and the increasing numbers of uninsured children in working poor families with income too high to qualify for Medicaid, the SCHIP legislation was enacted. SCHIP allows States to implement several options to expand coverage for uninsured children in families with incomes up to 200 percent of the FPL or 50 percentage points above the Medicaid income eligibility in effect in March 1997. SCHIP is a flexible program that allows States to increase eligibility by expanding the Medicaid system, creating separate programs, or using a combination of both approaches. SCHIP also has stimulated changes in the traditional Medicaid program in areas such as simplifying eligibility and enrollment, and has placed a new emphasis on finding and enrolling hard to reach populations.

The children's insurance programs in many States are aggressively enrolling children into both SCHIP and Medicaid. There are multiple efforts on the national, State, and local levels to get uninsured children covered. The following are examples of some of these efforts.

- Nationally, eight Federal Departments have responded to President Clinton's 1998 directive to work cooperatively to develop plans to educate working families about SCHIP and assist in the enrollment of children in Medicaid or SCHIP.
- Indiana enrolls children using 500 independent enrollment centers throughout the State to reduce the stigma of applying for SCHIP/Medicaid at welfare offices. Enrollees are issued a card resembling a commercial insurance card that refers to enrollees as members.
- Ohio formed a partnership with the Internal Revenue Service to have HealthyStart materials accompany their Earned Income Tax Credit brochure to the volunteer tax preparation sites.
- California reduced its 28-page SCHIP/Medicaid application form to a 4-page more user-friendly application, translated into 11 languages.
- In Maryland, a consortium of an advocacy group, a national non-governmental organization, and a school of nursing sponsored a "wellmobile" that conducted outreach activity in two Maryland counties.

- Illinois allows families to mail in their KidCare applications, encouraging working families to apply.

MEDICAID AND THE HEALTH OF LOW-INCOME CHILDREN

Medicaid coverage has provided the foundation on which a comprehensive pediatric health care program is based. Without Medicaid, low-income children would not have full access to well-child visits, immunizations, lead screenings, vision and hearing services, dental care, developmental screening, adolescent counseling services, mental health care, long- term care and treatment for chronic illness. Without Medicaid, low-income females would not have full access to prenatal care and coverage of family planning and other obstetric services that are vital to the health of their newborns.

Acute and chronic illnesses disproportionately affect low-income children (Dutton, 1985, Shatin et al., 1998). Among children, poverty is related to poorer cognitive function, shorter stature, higher serum lead levels, more dental caries, and more severe asthma (Kramer, Allen, and Gergen, 1995; Yip, Scanlon, and Trowbridge, 1993; Persky et al., 1998; Vargas, Crall, and Schneider, 1998). Chronic and acute health problems affect children in all income groups, but children from low-income families spend more days in bed, experience more hospitalizations and have longer stays, and visit emergency departments more frequently than children from higher income families (Newacheck and Starfield, 1988; Shatin et al., 1998). The higher burden of illness among children from low-income families leads to disproportionate expenditures for medical care. Without Medicaid coverage, low-income families would be unable to afford premiums and other out-of-pocket costs associated with private insurance. While medical expenditures for children in the lowest income levels are higher than expenditures for all but the highest income children, low-income children continuously covered by Medicaid have lower out-of-pocket expenses than low income privately insured or uninsured children (Newacheck and Halfon, 1986).

Research has demonstrated the effectiveness of health insurance in improving the health of low income children. An experiment in the mid-1960s randomized comprehensive care to a group of poor urban families (Alpert et al., 1968). Relative to the control group, the children who received these services made an average of 75 percent more well-child visits, and 32 percent fewer sick visits. The results of this experiment, which coincided with the enactment of Medicaid, indicated that eliminating the financial barrier to health services is necessary to improve access to comprehensive care of children. Other studies show that children with health insurance are significantly more likely to have a usual source of care, to receive medical care when needed, and to get needed medications, mental health care, or eyeglasses, than children without (Newacheck et al., 1998). Medicaid coverage provides children with the financial resources needed to obtain quality care.

The importance of Medicaid can also be seen in its impact on key indicators of the health of children. A number of advances in health care for children have occurred since the inception of Medicaid that probably would not have occurred in the program's absence. The first full decade of Medicaid (1970-1980) saw infant mortality drop 35 percent, the most rapid decline of the century, with neonatal mortality (ages 0-27 days) plummeting 41 percent (Centers for Disease Control and Prevention, 1999). In that same decade,

deaths in early childhood (ages 1-4 years) declined 24 percent, 26 percent, for school-aged children (5-14 years), and 25 percent for older adolescents and young adults (Centers for Disease Control and Prevention, 1999). The greatest period of decline for measles, mumps, and rubella also occurred in the first decade of Medicaid. Outbreaks of these diseases have continued throughout the 1970s, 1980s, and early 1990s, primarily because there were substantial numbers of hard-to-reach underimmunized low-income infants and preschool aged children. In the 1990s, the Centers for Disease Control and Prevention (CDCP) and State health agencies mounted aggressive efforts to immunize children in this age group. Some States initiated purchasing programs to supply Medicaid providers with free vaccines. This effort has resulted in a 99-percent reduction in measles, a 62-percent reduction in mumps, a 90-percent reduction in rubella between 1980 and 1998 (National Center for Health Statistics, 1999; Centers for Disease Control and Prevention, 1998). In the same years, the sometimes fatal disease, invasive Haemophilus influenza type b, has been virtually eradicated (Reuters, 1998). None of this could have been accomplished without Medicaid coverage of immunizations.

Although the Medicaid program has successfully insured millions of children, most studies have shown that the levels of use of services by Medicaid covered children, while higher than uninsured, are lower than those of privately insured children (St. Peter, Newacheck, and Halfon, 1992). The new adage is that insurance is necessary but not sufficient to assure that children receive the care that they need. A large number of factors have been shown to affect receipt of medical services among Medicaid-eligible children (Gadomski, Jenkins, and Nichols, 1998; Freed et al., 1999; Strobino et al., 1996; Cornelius, 1993; Cohen and Cunningham,1995; Riportella-Muller et al., 1996; Moore and Hepworth, 1994; Pierce et al., 1996; Wood et al.,1995; Bobo et al., 1993; Pappas et al., 1997; Moore, Fenlon, and Hepworth, 1996; Snowden, Libby, and Thomas, 1997; Gary, Campbell, and Serlin, 1996; Abbotts and Osborn, 1993). Medicaid managed care is, in part, an attempt to address these disparities in access to care between low-income children and those of greater means.

Has managed care achieved its goal of improving access to care for low-income children? The results of some studies suggest that managed care has had a neutral result (Oleske et al., 2000; Szilagyi, 1998; Coughlin and Long, 1999). Other studies, however, have found encouraging results. The Florida Healthy Kids Program, a State-funded school based health program piggy-backed on the school lunch program (Rosenbach, Irvin, and Coulam, 1999), is a mixed privatized and public model. A private non-profit agency oversees agreements among private contractors, the school districts, and State agencies to provide comprehensive care to school aged children. These children had fewer unmet health needs, fewer emergency department visits, and more physician visits than children did in a comparison group. Through the use of SCHIP funding, Florida has expanded this program to cover more children. A Maryland PCCM program in which a primary care physician was assigned to each child, resulted in a 120-percent increase in the probability of an enrolled child having a well-child care visit, and a 10-percent decrease in the probability of having an avoidable hospitalization (Gadomski, Jenkins, and Nichols, 1998). Implementation of Tennessee's section 1115 demonstration project (TennCare) resulted in a 30-percent improvement in continuity of care for infants (Cooper et al.,

1999). In North Carolina, implementation of PCCM type Medicaid managed care program resulted in a 37-percent decrease in the average monthly rate of non-urgent emergency department visits (Piehl, Clemens, and Joines, 2000). When care is taken to implement managed care programs that target multiple barriers to care, they can improve access and health outcomes.

The 1980s expansions resulted in the greatest increase in Medicaid enrollment to date. Between 1987 and 1994, enrollment increased from 13.3 million to 20.7 million, a 60-percent change (Dubay et al., 1995). Four States that were evaluated after the expansions demonstrated increases in the number and completion of immunizations, increases in well-child care visit rates for infants, and slight increases in use of preventive dental services (Herz, Chawla, and Gavin, 1998). Overall, States responded to the increase in enrollees by increasing the average volume of participating pediatricians' preventive services, or by increasing the number of physicians providing preventive care (Adams and Graver, 1998). The 1989 expansion also was associated with an increased use of prenatal services (Cole, 1995), and, in Florida, a decrease in the number of low-birth weight infants. Despite these increases in the use of services and improved outcomes, great disparities remained between the poor and non-poor.

CHALLENGES AND OPPORTUNITIES

Medicaid and SCHIP have succeeded in their goals of improving the health of our Nation's most vulnerable children. Changes in these programs over the years have increased their effectiveness, and allowed increasing numbers of needy children to be served. Despite these advances, however, many children still do not have adequate access to basic health care services. Even for children participating in Medicaid and SCHIP, access to care is still less than that enjoyed by privately insured children. More work needs to be done to ensure that all of our children have access to quality health care. Healthy children are necessary for a healthy Nation.

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Medicaid: 35 Years of Service

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On this 35th anniversary of the enactment of Medicaid, it is important to reflect on the program's role in the U.S. health care system. The Medicaid program is the third largest source of health insurance in the United States—after employer-based coverage and Medicare. The significance of Medicaid's role in providing health insurance cannot be overstated. As the largest in the Federal safety net of public assistance programs, Medicaid provides essential medical and medically related services to the most vulnerable populations in society. In 1998, the Medicaid program covered 41.4 million[1] low-income children, their families, elderly people, and individuals with disabilities—approximately 12 percent of the total U.S. population.[2]

Since its inception in 1965, Medicaid enrollment and expenditures have grown substantially. In addition, the program has evolved as Federal and State governments balance social, economic, and political factors affecting this and other public assistance programs. This article presents an overview of the Medicaid program and highlights trends in enrollment and expenditures.

OVERVIEW

Medicaid was enacted in the same legislation that created the Medicare program—the Social Security Amendments of 1965 (Public Law 89-97). Prior to the passage of this law, health care services for the indigent were provided primarily through a patchwork of programs sponsored by State and local governments, charities, and community hospitals.

Before 1965, Federal assistance to the States for the provision of health care was provided through two grant programs. The Social Security Amendments of 1950 provided Federal matching funds for State payments to medical providers on behalf of individuals receiving public assistance payments. In 1960, the Kerr-Mills Act created a new program called Medical Assistance for the Aged. This means-tested grant program provided Federal funds to States that chose to cover the medically needy aged, who were defined as elderly individuals with incomes above levels needed to qualify for public assistance but in need of assistance for medical expenses.

In 1965, Congress adopted a combination of approaches to improve access to health care for the elderly. The Social Security Amendments of 1965 created a hospital insurance program to cover nearly all of the elderly (Medicare Part A), a voluntary supplementary medical insurance program (Medicare Part B), and an expansion of the Kerr-Mills program to help elderly individuals with out-of-pocket expenses, such as premiums, copayments, deductibles, and costs for uncovered services. At the same time, Congress decided to extend the Kerr-Mills program—now the Medicaid program—to cover additional populations including families with children, the blind, and the disabled.

In general, Medicaid provides three types of critical health protection: (1) health insurance for low-income families

[1] Enrollment data from HCFA Form 2082.

[2] Data from HCFA's Office of the Actuary. The percent of the population covered by Medicaid was estimated using average Medicaid enrollment data and U.S. Census Bureau estimates of the national population.

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and people with disabilities; (2) long-term care (LTC) for older Americans and individuals with disabilities; and (3) supplemental coverage for low-income Medicare beneficiaries for services not covered by Medicare (e.g., outpatient prescription drugs) and Medicare premiums, deductibles, and cost sharing.

Medicaid is a joint Federal and State program. Each State establishes its own eligibility standards, benefits package, payment rates, and program administration under broad Federal guidelines. As a result, there are essentially 56 different Medicaid programs—one for each State, territory, and the District of Columbia.

Eligibility

Medicaid eligibility is based on a combination of financial and categorical requirements. Medicaid is a means-tested program. Beneficiaries must be low-income and meet certain asset and resource standards. Each State determines income thresholds and resource standards for their Medicaid program, following Federal guidelines. These thresholds and standards can vary by State, and may differ for each Medicaid-eligible population group within a State (i.e., children, adults, elderly, individuals with disabilities.)

Medicaid does not provide medical assistance to all low-income individuals. Traditionally, Medicaid has been available only to persons in certain categories: members of families with children and pregnant women, and to persons with disabilities or who are aged or blind. Low-income individuals who did not fit into one of these categories, such as childless couples or adults without disabilities, typically did not qualify for Medicaid—regardless of how low their income. Program waivers and additional mandatory eligibility groups have provided States with opportunities to extend Medicaid services to populations beyond the traditional welfare-defined groups.

Initially, eligibility for Medicaid was linked to receipt of cash assistance from Aid to Families with Dependent Children (AFDC) and, starting in 1972, Supplemental Security Income (SSI). Over time, legislative changes to the Medicaid program and the AFDC welfare program have led to the creation of certain Medicaid groups where eligibility is based solely on income and resources, not receipt of cash assistance. Some of these non-cash groups are referred to as the poverty-related groups. Congress created these groups in the late 1980s in an effort to expand Medicaid coverage of pregnant women and children by delinking Medicaid eligibility from receipt of AFDC. Poverty-related groups are an increasing proportion of Medicaid eligible individuals.

The Medicaid statute identifies certain populations that States are required to cover and other populations that States may choose to cover. All States must provide Medicaid coverage to the following eligibility groups:

- *Certain low-income families*—States are required to provide Medicaid to individuals who meet the requirements of the AFDC program that were in effect in their State as of July 16, 1996.
- *Poverty-related groups*—States are required to provide Medicaid to certain pregnant women and children under age 6 with incomes up to 133 percent of the Federal poverty level (FPL). States must also cover all children born after September 30, 1983, with incomes up to 100 percent of FPL. This requirement will result in the mandatory coverage of all children below 100 percent of FPL under age 19 by 2003.
- *Current and some former recipients of SSI*—States are generally required to provide Medicaid to recipients of SSI.

States, however, may use more restrictive eligibility standards for Medicaid than those used for SSI if they were using those standards prior to the enactment of SSI in 1972.

- *Foster care and adoption assistance*—States must provide Medicaid to all recipients of foster care and adoption assistance under Title IV-E of the Social Security Act.
- *Certain Medicare beneficiaries*—State Medicaid programs must provide supplementary assistance to low-income Medicare beneficiaries. All Medicare beneficiaries with incomes below the FPL receive Medicaid assistance for payment of Medicare premiums, deductibles, and cost sharing. These individuals are qualified Medicare beneficiaries (QMBs). In addition, individuals at the lowest income levels are entitled to full Medicaid benefits, which provide coverage for services not covered by Medicare such as outpatient prescription drugs. Medicare beneficiaries with income levels slightly higher than the FPL receive Medicaid assistance for payment of Medicare premiums. These individuals are specified low-income Medicare beneficiaries (SLMBs).

States have the option to provide Medicaid coverage to other groups. These optional groups fall within the defined categories previously mentioned but the financial eligibility standards are more liberally defined. Optional eligibility groups include:

- *Poverty-related groups*—States may choose to cover certain higher-income pregnant women and children defined in terms of family income and resources. For example, some States have chosen to cover pregnant women and infants with family incomes up to 185 percent of FPL or higher.
- *Medically needy*—States may choose to cover individuals who do not meet the financial standards for program benefits but fit into one of the categorical groups and have income and resources within special medically needy limits established by the State. Individuals with incomes and resources above the medically needy standards may qualify by spending down—i.e., incurring medical bills that reduce their income and/or resources to the necessary levels.
- *Recipients of State supplementary income payments*—States have the option to provide Medicaid to individuals who are not receiving SSI but are receiving State-only supplementary cash payments.
- *LTC*—States may cover persons residing in medical institutions or receiving certain LTC services in community settings if their incomes are less than 300 percent of SSI.
- *Working disabled*—States have the option to provide Medicaid to working individuals who are disabled, as defined by the Social Security Administration, who cannot qualify for Medicaid under any statutory provision due to their income. If States choose to cover this group, then they may also cover individuals who lose Medicaid eligibility as a result of losing SSI due to medical improvement.

States also have the discretion to expand eligibility beyond these optional groups. Through demonstrations, such as the 1115 research and demonstration project authority, and statutory provisions that allow less restrictive methodologies for calculating income and resources (i.e., section 1902(r)(2)), States may provide Medicaid services to individuals who do not meet standard Medicaid financial or categorical requirements. This discretion has aided States significantly in their health care reform efforts.

Financing

The Medicaid program is jointly financed by the States and the Federal Government. Medicaid is an entitlement program and the Federal spending levels are determined by the number of people participating in the program and services provided. Federal funding for Medicaid comes from general revenues. There is no trust fund for Medicaid as there is for Medicare Part A or Social Security.

The Federal Government contributes between 50 percent and 83 percent of the payments for services provided under each State Medicaid program. This Federal matching assistance percentage varies from State to State and year to year because it is based on the average per capita income in each State. States with lower per capita incomes relative to the national average receive a higher Federal matching rate. The Federal matching rate for administrative costs is uniform for all States and is generally 50 percent, although certain administrative costs receive a larger Federal matching rate.

Services

The Medicaid benefit package is defined by each State, based on broad Federal guidelines. There is much variation among State Medicaid programs regarding not only which services are covered, but also the amount of care provided within specific service categories (i.e., amount, duration, and scope of services).

Each State Medicaid program must cover mandatory services identified in statute. Some of the mandatory services include: inpatient and outpatient hospital services, physicians' services, rural health clinic and federally qualified health center (FQHC) services, laboratory and X-ray services, and well-child services (i.e., Early and Periodic Screening, Diagnosis, and Treatment Services [EPSDT]). In addition to the mandated services, States have the discretion to cover additional services—i.e., optional services. States may choose among a total of 33 optional services to cover under their Medicaid programs, including prescription drugs, physical therapy, dental services, and eyeglasses.

Major Legislative Milestones

Since Medicaid was enacted, the Federal Government has made significant changes in program eligibility criteria, financing, and services provided. In addition, States have used their discretion to implement their own changes in the program. Many of the changes to the Medicaid program have been in response to the growing number of low-income individuals in need of medical assistance, the need to improve access to care, and the need to contain the rising costs of providing medical assistance. The following are some of the legislative changes since the Medicaid program was established in 1965.

1965—The Medicaid Program, authorized under Title XIX of the Social Security Act, is enacted to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities.

1967—EPSDT comprehensive health services benefit for all Medicaid children under age 21 is established.

1972—Medicaid eligibility for elderly, blind, and disabled residents of a State can be linked to eligibility for the newly enacted Federal SSI program if a State chooses.

1981—Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) are established; States are required to provide additional

payments to hospitals treating a disproportionate share of low-income patients (i.e., disproportionate share hospitals [DSH]).

1986—Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of FPL is established as a State option.

1988—Medicaid coverage for pregnant women and infants to 100 percent of FPL is mandated; special eligibility rules are established for institutionalized persons whose spouse remain in the community to prevent spousal impoverishment; QMB group is established to pay Medicare premiums and cost-sharing charges for beneficiaries with incomes and resources below established thresholds.

1989—Medicaid coverage of pregnant women and children under age 6 to 133 percent of FPL is mandated; expanded EPSDT requirements are established.

1990—Phased-in coverage of children ages 6-18 under 100 percent of FPL is established; Medicaid prescription drug rebate program established; SLMB eligibility group is established.

1991—DSH spending controls established; provider donations are banned; provider taxes are capped.

1996—Welfare Reform—AFDC entitlement program is replaced by the Temporary Assistance for Needy Families (TANF) block grant; welfare link to Medicaid is severed; enrollment/termination of Medicaid is no longer automatic with receipt/loss of welfare cash assistance.

1997—Balanced Budget Act of 1997 (BBA)—State Children's Health Insurance Program (SCHIP) is created; limits on DSH payments are revised; new managed care options and requirements for States are established.

MEDICAID PROGRAM TRENDS

Beneficiaries

One indicator of Medicaid growth and program evolution is the trend in enrollment. In 1978, Medicaid covered approximately 9 percent of the total U.S. population. By 1998, Medicaid covered 12 percent of the total U.S. population. Many factors contribute to this increase in coverage; the most significant is the creation of new eligibility groups.

The number of individuals served by the Medicaid program remained relatively constant from 1977 to 1989. The eligibility expansions mandated in the 1980s led to significant increases among certain eligibility groups, especially pregnant women and children. Prior to implementation of these expansions, the number of persons served was approximately 23.5 million in 1989. This number reached 36.3 million in 1995 (Figure 1).

A recent decline in the number of individuals enrolled and served through Medicaid is attributed to a variety of factors including: fewer people in poverty, lower rates of unemployment, and the delinking of Medicaid and welfare assistance in 1996 (i.e., the inappropriate termination of families who lost eligibility for cash assistance but retained eligibility for Medicaid). In particular, there has been a steady decline in the number of children enrolled in Medicaid since 1996 (Figure 2).

Projections of Medicaid enrollment for the next decade show moderate growth compared with the 1990s. Total enrollment, measured in person years (i.e., full year equivalent enrollees), is currently projected to increase at an annual average rate of about 1 percent, from 32.5 million in 1998

to 37.6 million in 2010. The blind and disabled population is projected to increase at twice the rate of all other eligibility groups.

Another enrollment trend is the increase in the number of non-cash beneficiaries. Non-cash beneficiaries qualify for Medicaid based solely on their income and resources (e.g., poverty-related groups). The establishment of non-cash eligibility groups allows States to provide Medicaid to low-income individuals such as the working poor whose incomes preclude them from qualifying for cash assistance. With the creation of non-cash eligibility groups, Medicaid has evolved to serve more than just welfare families. In fiscal year (FY) 1998, less than one-half (42.7 percent) of all Medicaid enrollees received some form of welfare cash assistance, and over 25 percent of beneficiaries were classified as poverty related (Figure 3).

Women and Children

Not surprisingly, females comprise a larger share of the Medicaid population (57.4 percent) than males (38.8 percent) due to their roles as mothers of children and their greater likelihood of nursing home entry (Figure 4). Medicaid provides protection for low-income women and their families from exhausting limited income and resources on LTC services. Medicaid has also had an impact on women's health.

Expansions in Medicaid eligibility coupled with presumptive eligibility for pregnant women and targeted outreach efforts (e.g., outstationed eligibility workers) have increased the availability of prenatal care services for pregnant women. The proportion of all women giving live births who started prenatal care during the first trimester increased from 75.8 percent in 1990 to 82.8 percent in 1998. Infant mortality (under 1 year of age) has decreased from 9.2 deaths per 100,000 live births in 1990 to 7.2 deaths per 100,000 live births in 1998 (National Center for Health Statistics, 2000).

Medicaid plays a prominent role in providing health insurance to low-income children. Historically, children have represented the largest eligibility group served by Medicaid. The eligibility expansions in the 1980s, coupled with a recession, contributed to the significant growth in enrollment of children throughout the early 1990s.

By the mid to late 1990s, lower unemployment rates, due to a strong economy, contributed to a decline in Medicaid enrollment. Between 1995 and 1998, the proportion of children covered by Medicaid dropped from 23.2 percent to 19.8 percent. As Medicaid enrollment has declined, the percent of uninsured children increased from 13.8 percent in 1995 to 15.4 percent in 1998 (U.S. Bureau of the Census, 2000) (Figure 5).

Medicaid coverage of children is significant among all age groups. However, coverage is more prevalent among younger aged children. From 1987 to 1993, Medicaid coverage of children under age 3 climbed from 19.0 percent to 34.6 percent. However, by 1998 the proportion of children under age 3 covered by Medicaid had dropped to 25 percent. Similar trends occurred in other age groups. In the age group 3-5, 17.8 percent of children were covered by Medicaid in 1987, increasing to 29.8 percent in 1993, and then dropping to 22.9 percent in 1998. Less dramatic changes were seen for children in the age group 12-17. In 1987, 11.7 percent of this age group was covered by Medicaid with this increasing to 16.6 percent by 1993, and decreasing slightly by 1998 to 15.5 percent (Figure 6).

Children (including children with disabilities) represent 54 percent of the 41.4 million individuals enrolled in Medicaid in FY 1998. The children Medicaid served in

FY 1998 represented one out of five children in the Nation. Over one-third of all children in the U.S. under age 6 received Medicaid services in FY 1998 (Figure 7).

Elderly

The number of Medicaid beneficiaries, age 65 or over, has grown only slightly over time. Growth in the number of elderly Medicaid beneficiaries has been much lower than the increase in the elderly U.S. population as a whole. In 1975, Medicaid covered 3.6 million older Americans or roughly 17 percent of the 21.7 million Americans age 65 or over. In 1998, Medicaid served nearly 4 million elderly beneficiaries, or 12 percent of the 32.4 million age 65 or over population (U.S. Bureau of the Census, 1999).

The elderly's representation among all Medicaid beneficiaries has actually declined over time. In 1973, the population age 65 or over represented 19 percent of all Medicaid beneficiaries. In 1998, individuals age 65 or over represented 11 percent of the Medicaid population (U.S. Bureau of the Census, 1999).

Medicaid beneficiaries age 65 or over account for a disproportionate share of total Medicaid expenditures. This is due to the high cost of services utilized by this population (e.g., LTC facilities) and not the size of the population. In 1998, elderly beneficiaries represented 11 percent of total Medicaid persons served yet they accounted for 31 percent of total Medicaid expenditures (Figure 8).

Individuals with Disabilities

The fastest growing Medicaid eligibility group is the disabled. Medicaid served approximately 6.6 million individuals with disabilities in FY 1998. The proportion of Medicaid beneficiaries with disabilities has increased over time. In FY 1973, the blind and disabled represented 11 percent of the total Medicaid population receiving services with this growing to 18 percent by FY 1998 (Figure 9).

In terms of provider payments, growth in expenditures for the blind and people with disabilities outpaced other eligibility groups. In 1978, blind and disabled individuals served through Medicaid represented 32.4 percent of total provider payments. By 1998, the blind and individuals with disabilities accounted for 43.6 percent of total provider payments (Figure 10).

One contributing factor to the growth in this eligibility group and expenditures during this time period has been the acquired immunodeficiency syndrome (AIDS). Medicaid is the largest single payer of direct medical services for persons living with AIDS. Medicaid serves over 50 percent of all persons living with AIDS, and up to 90 percent of all children with AIDS (Health Care Financing Administration, 2000a). HCFA estimates combined Federal and State Medicaid expenditures for beneficiaries with AIDS at $4.1 billion in FY 2000.

Services

Institutional LTC Services

The most significant trend in Medicaid services is the growth in LTC expenditures. Medicaid is the primary source of LTC insurance for the elderly and people with disabilities, including middle-income individuals who spend down their financial resources. Medicaid covers skilled nursing facility care, intermediate care facilities for the mentally retarded and developmentally disabled, and home and community-based services.

Medicaid's role as primary insurer for LTC has grown significantly. In 1968, Medicaid accounted for about 24 percent of total nursing home care expenditures.

In 1998, total Medicaid expenditures (State plus Federal expenditures) for nursing facility services were $44.1 billion. This accounts for almost one-half (46 percent) of all U.S. spending on nursing home care (Health Care Financing Administration, 2000b).

The magnitude of Medicaid's nursing facility expenditures reflects the high cost of these services as well as the limited coverage under Medicare and private insurance. Nursing facility expenditures also drive the distribution of Medicaid spending among beneficiaries. In 1998, only 4 percent (1.6 million) of all persons served by Medicaid received nursing facility services. However, the $44.1 billion spent on their service accounted for approximately 25 percent of total Medicaid expenditures.

Home and Community-Based Services

Although most LTC is for institutional care, Medicaid has made great strides in shifting the delivery of services to home and community-based settings. Medicaid's home and community-based services waiver program (i.e., 1915(c) waivers) affords States the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals. States have the flexibility to design a waiver program and select the mix of services including certain non-medical, social and supportive services to best meet the needs of the population they want to serve in the home or community.

States are using these programs to provide services to a diverse LTC population, including the elderly, individuals with physical and developmental disabilities, those with chronic mental illness, mental retardation, and persons with AIDS. During FY 1998, home and community-based waivers served over 467,000 beneficiaries. As of April 1999, 240 1915(c) waiver programs were operating in 49 States (Health Care Financing Administration, 1999). Community-based LTC increased from 14.9 to 25.3 percent of LTC spending from 1992 to 1998 (Figure 11).

In 1998 Medicaid accounted for 17 percent of total spending on home health care in the U.S. (Health Care Financing Administration, 2000b). Unlike the home health benefit under Medicare, Medicaid does not require individuals to have a need for skilled care in order to qualify for services. Medicaid home health generally is a LTC benefit for low-income individuals.

Medicaid Expenditures

From the inception of the Medicaid program through the late 1980s, overall Medicaid spending grew at a rate that was comparable to national health spending. Since then, however, Medicaid average annual spending growth has outpaced the rate of growth in national health spending. Medicaid expenditures have nearly tripled since the late 1980s. By FY 1998, total Medicaid program spending reached $175.1 billion. The average annual real growth rate in total spending was 5.9 percent throughout the 1980s. During the 1990s, the average annual real growth rate increased to 9.8 percent, most of which occurred in the early 1990s.

Medicaid's share of national health spending has increased over the past three decades. In 1966, Medicaid spending accounted for only 2.9 percent of total national health expenditures. By 1998, Medicaid as a share of health care spending had risen to 14.8 percent, approximately a 5-fold increase over the 32-year period. The total public sector portion of national health care expenditures increased from 30.2 percent in 1966 to 45.4 percent in 1998 (Figure 12).

A variety of factors contribute to the annual growth rate in Medicaid program expenditures. Changes in Federal and State policy, for example, have a significant impact on spending. Congressionally mandated expansions in Medicaid eligibility categories explain some of the expenditure growth. However, program spending increased the fastest between 1989 and 1992, mainly as a result of State provider tax and donation mechanisms designed to maximize Federal Medicaid payments. Several factors account for the relatively slow growth of Medicaid spending in recent years: a booming economy which has slowed enrollment growth; lower medical price inflation; the expansion of managed care and other cost containment measures; and restrictions on DSH expenditure growth (Figures 13 and 14).

Many of the factors contributing to the recent slowdown in spending growth will be temporary, producing a gradual return to future higher growth rates. For example, the projected rate of DSH spending will slow considerably in the near term as a result of reductions in annual allotments. While DSH payments account for a large part of the increased spending during the past decade, HCFA estimates that Medicaid expenditures on behalf of children and individuals with disabilities will drive future spending: both groups have the highest expenditure growth rates and the disabled account for the largest share of Medicaid expenditures. Total Medicaid spending is currently projected to reach $444 billion in FY 2010. Case-load growth accounts for about one-sixth of the increase during this period; inflation accounts for one-third; and the balance can be explained by spending per enrollee in excess of inflation (HCFA, 2000c).

HCFA projects that total Medicaid outlays will grow at an average annual rate of about 8 percent between FYs 1998 and 2010. DSH expenditures will grow the least (a 1-percent annual average), while spending for people with disabilities and children will grow the most (9 percent annual average), followed by adults (8 percent) and the elderly (7 percent) (HCFA, 2000c).

Medicaid spending accounts for a significant portion of State budgets. In FY 1999, over 14 percent of total State general funds were spent on Medicaid. In addition, over 43 percent of total Federal funds provided to States in FY 1999 were spent on Medicaid (Figure 15).

Administrative Expenses

Medicaid administrative expenses are low compared with that of private insurance. For much of the past 30 years, Medicaid administrative expenses, as a percent of total program expenditures, have remained fairly constant—between 4.0 and 6.5 percent—compared with approximately 12 percent for major insurance plans. Overall growth rates for the most part have been relatively flat but suggest a gradual increase over the period with somewhat greater fluctuation in the past 4 years. Administrative expenses have risen by 2.5 percentage points in the past year to reach a 32-year high of 6.5 percent (Health Care Financing Administration, 2000b).

Spending By Eligibility Group

During the past two decades, Medicaid spending on behalf of the blind, individuals with disabilities and the elderly has grown significantly. This change reflects the growing Medicaid disabled population and the spiraling costs associated with institutional LTC services.

While the aged, the blind, and people with disabilities account for only 26 percent of all Medicaid persons served in FY

1998, the Medicaid payments made on their behalf account for 71 percent of program payments. The largest group, children, account for only 16 percent of all Medicaid payments (Figure 16).

This pattern in distribution of Medicaid payments by eligibility group goes back to the mid-1970s. Since 1975, Medicaid payments for the elderly and disabled have exceeded payments for adults and children. During the late 1970s and early 1980s, payments for the elderly and the disabled have generally been similar, with payments for the elderly slightly higher. Starting in 1987, however, payments for individuals with disabilities began to surpass payments for the elderly. Furthermore, since 1992, there has been a dramatic growth in spending for the disabled (Figure 17).

Between FYs 1978 and 1998, real per capita spending for elderly Medicaid beneficiaries grew the fastest among all eligibility groups (an average annual growth rate of 4.9 percent). Per capita program payments on behalf of the blind and disabled grew somewhat slower (a 3.7-percent average annual increase). In contrast, spending for children and adults grew at more modest rates (average annual growth rates of 2.8 and 2.2 percent, respectively) (Figure 18).

Dual eligible beneficiaries are Medicare beneficiaries who also qualify for Medicaid benefits due to their low income. Medicaid spends a disproportionate share of program funds on behalf of dual eligible beneficiaries. During FY 1997, 6.4 million dual eligibles represented only 19 percent of the Medicaid population, but accounted for 35 percent of program expenditures (Clark and Hulbert, 1998).

Medicaid Managed Care

One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery method. Federal outlays for Medicaid premium payments to Medicaid managed care plans increased from $700 million in FY 1988 to $13.2 billion in FY 1998. State interest in pursuing Medicaid managed care initiatives began in the early 1980s when a combination of rising Medicaid costs and the national recession put pressure on States to control spending growth. Since then, States have continued to experiment with various managed care approaches in their efforts to reduce unnecessary utilization, contain costs, and achieve greater coordination and continuity of care.

Throughout the 1990s, States significantly expanded their Medicaid managed care programs. In 1991, less than 10 percent of all Medicaid beneficiaries were enrolled in managed care plans. By 1998, nearly 54 percent (16.5 million) of the Medicaid population was enrolled in managed care plans (Figure 19).

Although Medicaid managed care enrollment has grown rapidly in the aggregate, wide variation in penetration rates exists among the States. Two States have no managed care enrollment (Alaska and Wyoming), 12 States have penetration rates between 76 and 100 percent (Arizona, Colorado, Delaware, Georgia, Hawaii, Iowa, Montana, New Mexico, Oregon, Tennessee, Utah, and Washington). The contrasts can even be observed between neighboring States such as North and South Carolina. During 1998, South Carolina enrolled 4 percent of beneficiaries in managed care while North Carolina had a 69-percent managed care penetration rate (Figure 20).

Most State Medicaid managed care enrollment consists of children and non-disabled adults. In 1998, individuals under age 21 represented over 55 percent of all Medicaid managed care enrollees, while adults age 21-64 represented nearly 29 percent of total managed care enrollment (HCFA Form 2082).

The elderly and the disabled are not traditionally pursued for managed care enrollment due to the challenge of delivering comprehensive services to these high need populations while controlling costs. Several States, however, have started to move non-elderly, disabled Medicaid beneficiaries into managed care. In 1998, approximately 1.6 million persons with disabilities were enrolled in Medicaid managed care programs operated by 36 different States (Regenstein and Schroer, 1998).

Managed Care Waivers

Medicaid program waivers play a significant role in the delivery of Medicaid services. Medicaid program waivers have allowed States to test Medicaid program innovations. The two primary mechanisms used for this are section 1915(b) Freedom of Choice waivers, and section 1115 research and demonstration projects.

Section 1915(b) waivers are used to mandatorily enroll beneficiaries in managed care programs; provide additional services via savings produced from managed care, create a carve-out delivery system for specialty care (e.g., behavioral health, etc.), and/or create programs that are not available statewide.

Section 1115 research and demonstration projects provide States with the flexibility to test substantially new ideas of policy merit. Under 1115 research and demonstration projects, States are testing programs that range from small-scale pilot projects testing new benefits or financing mechanisms, to major restructuring of State Medicaid programs. In 1998, 19 States had approved section 1115 research and demonstration projects, 17 of which were operating statewide.

LTC

States are increasingly interested in providing LTC services in a managed care environment. In addition to providing traditional LTC services (e.g., home health, personal care, institutional services, etc.) States are interested in providing non-traditional home and community-based services (e.g., homemaker services, adult day care, respite care, etc.) in their managed care programs as well. To achieve this, some States simultaneously utilize authorities under 1915(b) and 1915(c) to limit freedom of choice and provide home and community-based services. Currently, Texas and Michigan are operating concurrent 1915(b) and 1915(c) waivers.

SCHIP

In order to further address the problem of uninsured children, the SCHIP was created by BBA 1997. Designed as a State/Federal partnership, SCHIP was appropriated $24 billion over 5 years and $40 billion over 10 years to help States expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance.

SCHIP is designed to provide health insurance coverage to targeted low-income children who are not eligible for Medicaid or other health insurance coverage. A targeted low-income child is one who resides in a family with income below the greater of 200 percent of FPL or 50 percentage points above the State's Medicaid eligibility threshold. Most States have an upper eligi-

bility limit of 200 percent of FPL, however, some States have amended their SCHIP plans to expand coverage to more children.

SCHIP is the single largest expansion of health insurance coverage for children since the enactment of Medicaid. When enacted, the goal of BBA was to cover one-half of the 10 million uninsured children through Medicaid outreach and SCHIP expansions. It has provided States with a historic opportunity to reduce the number of uninsured children. As of January 1, 2000, each of the States and territories had an approved SCHIP plan in place. Of the 56 approved plans, 53 were implemented and operational during FY 1999.

The SCHIP law offers States three options for covering uninsured children. States can use SCHIP funds to provide coverage through separate children's health insurance programs, expand coverage available under Medicaid, or combine both strategies. States are using all three options for implementation.

Although most States use a Medicaid expansion as part of their SCHIP plan—either separately or in combination with a separate program—two thirds of all SCHIP children are being served through separate SCHIP programs. In FY 1999, nearly 2 million children were enrolled in the SCHIP program. States reported that over 1.2 million children were in new State-designed children's health insurance programs and almost 700,000 were enrolled in Medicaid expansion plans in FY 1999 (Figure 21).

Note on Data Sources

A majority of the information presented in this article is based on State-reported program data collected by HCFA (HCFA-2082 and HCFA-64). Each figure cites reference sources as well as notes to clarify the data.

Terminology

The terms enrollees and beneficiaries, as used in the article, refer to individuals who are enrolled in Medicaid, including individuals enrolled in Medicaid managed care plans. Medicaid data (HCFA-2082) refers to these individuals as eligibles.

The term persons served, as used in the article, refers to individuals for whom Medicaid program payments are made. Medicaid data (HCFA-2082) refers to these individuals as recipients. Starting in FY 1998, recipient data included individuals for whom managed care premium payments were made.

Data Caveats—HCFA-2082 and HCFA-64

Where real spending data is shown in the charts, adjustments have been made for inflation using the U.S. Bureau of Economic Analysis' estimates of the gross domestic product chain-type price index (1996=100). The chain-type price indexes used for these adjustments were published by the U.S. Bureau of Economic Analysis (2000).

Apparent inconsistencies in financial data are due to the difference in the information captured on the HCFA-2082 and HCFA-64. Adjudicated claims data are used in the HCFA-2082; actual payments are reported in the HCFA-64. The data presented within the figures showing total spending refers to the "Current Expenditure" line from the HCFA-64 and do not reflect payment adjustments or deductions. States claim the Federal match for payments to DSHs on the HCFA-64. Payments to DSHs do not appear on the HCFA-2082 since States directly reimburse these hospitals. Finally, the HCFA-64 includes data from Guam, Commonwealth of the Northern Mariana Islands, and American Samoa.

Medicaid Managed Care Enrollment Report

Data from this report is collected from State Medicaid agencies and HCFA. Data is presented for all States, the District of Columbia, the U.S. Virgin Islands, and Puerto Rico.

Current Population Survey (CPS)

The March 1995 CPS adopted new and revised health insurance questions. Caution should be used when comparing March 1995 estimates with earlier estimates. Generally, the changes in health insurance questions did not have a noticeable effect on overall health insurance estimates. However, there is an impact for estimates regarding specific types of coverage. For example, employer provided health insurance estimates increased significantly from 57 percent in 1993 to 61 percent in 1994. This increase is probably the result of a more straightforward set of private health insurance questions.

ACKNOWLEDGMENTS

The authors would like to thank the following HCFA staff for their contributions to this article: John Klemm, Sharman Stephens, Denise Franz, Roger Buchanan, Tony Parker, Lindy Hinman, and Andrew Fontanez.

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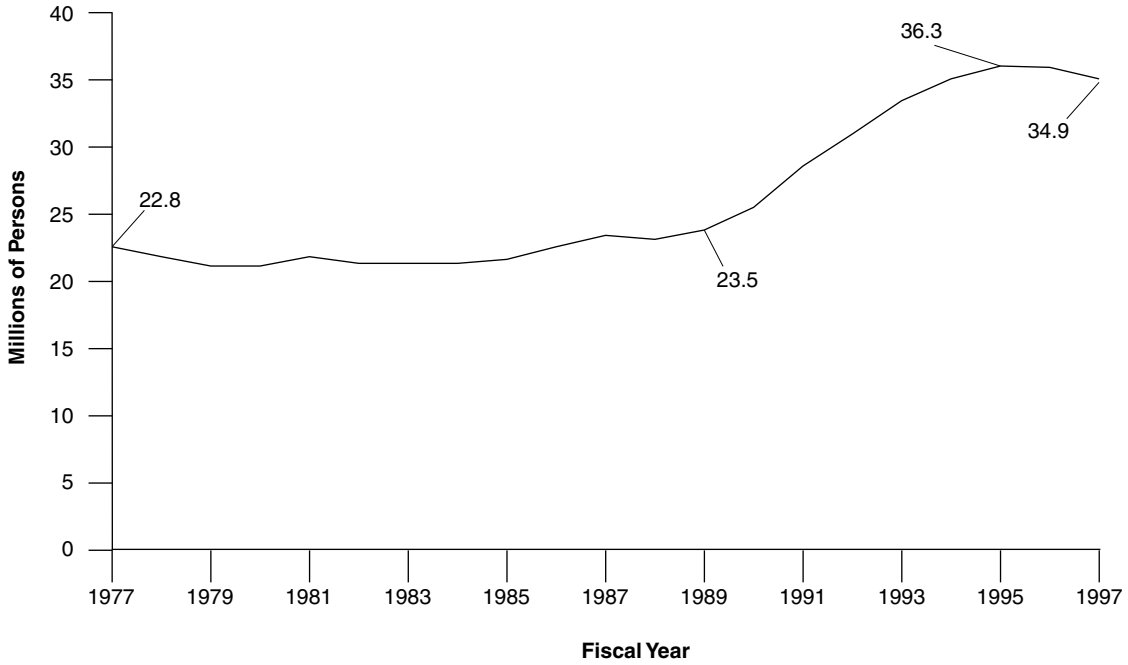
Reprint Requests: Christie Provost, M.P.P., Health Care Financing Administration, Room 325-H, Hubert H. Humphrey Building 200 Independence Avenue, SW., Washington, DC. E-mail: cprovost@hcfa.gov

Figure 1

Persons Served Through Medicaid, Fiscal Years 1977-1997

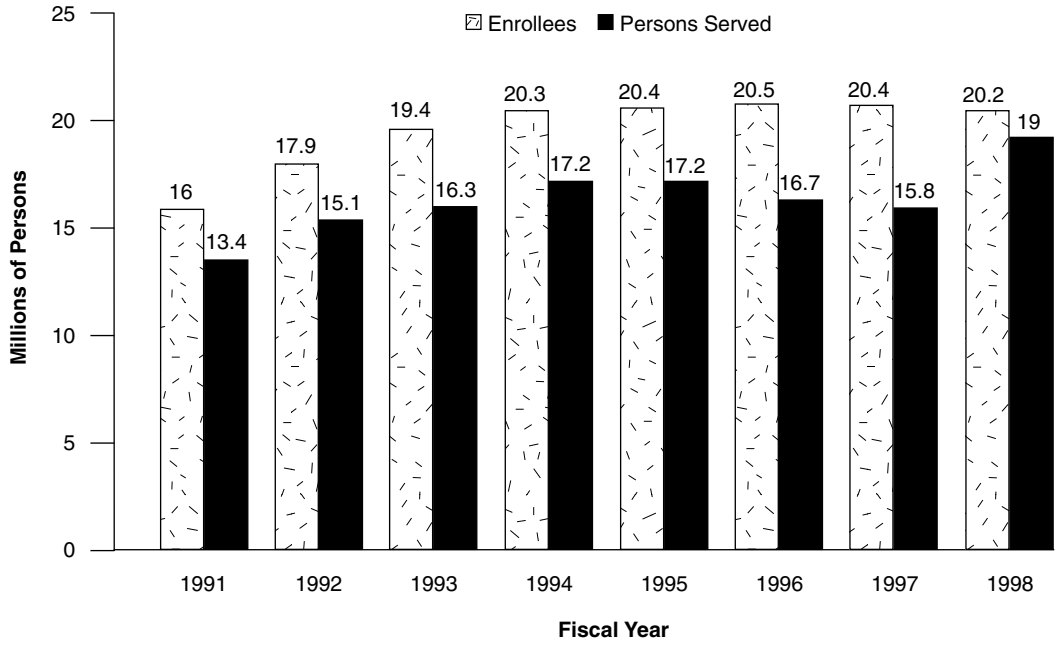


NOTES: The trend line presents a consistent time-series data set through 1997. In 1998, a large increase occurred in the number of persons served through Medicaid, which is mainly the result of a new reporting methodology of classifying payments to managed care organizations. FY 1998 was the first year capitation payments were counted as a service for purposes of the HCFA-2082 reporting, and thus managed care enrollees were included in the counts of individuals receiving services through Medicaid. Persons-served are individuals for whom a Medicaid claim was paid during the year.

SOURCE: Health Care Financing Administration, Office of Information Services: Data development by Enterprise Databases Group, data from the 1977-1997 HCFA Form 2082, 2000.

Figure 2

Medicaid Populations – Children, Fiscal Years 1991-1998

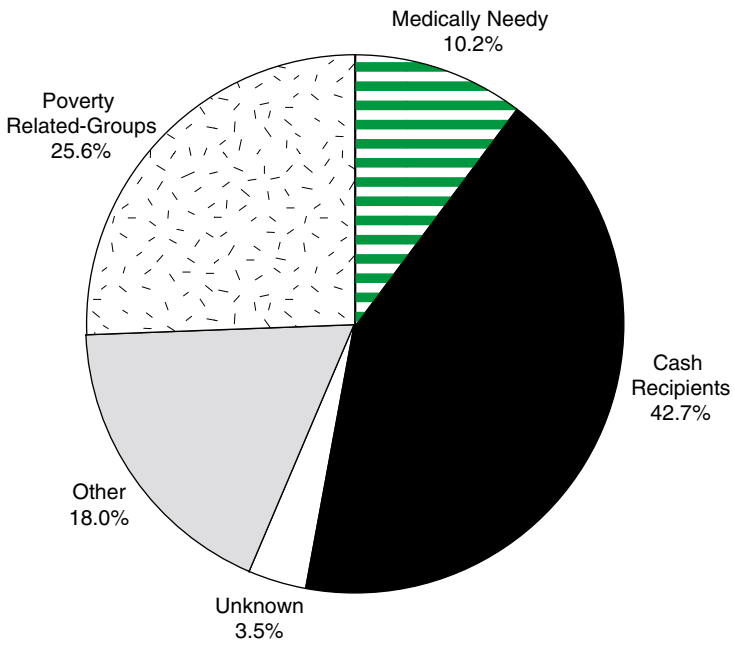


NOTES: In 1998, a large increase occurred in the number of persons served through Medicaid, which is mainly the result of a new reporting methodology of classifying payments to managed care organizations. FY 1998 was the first year capitation payments were counted as a service for purposes of the HCFA-2082 reporting, and thus managed care enrollees were included in the counts of individuals receiving services through Medicaid. Enrollees are individuals enrolled in Medicaid at least 1 month during the year. Persons served are individuals for whom a Medicaid claim was paid during the year or, beginning in 1998, on whose behalf Medicaid made premium payments to managed care organizations.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1991-1998 HCFA 2082, 2000.

Figure 3

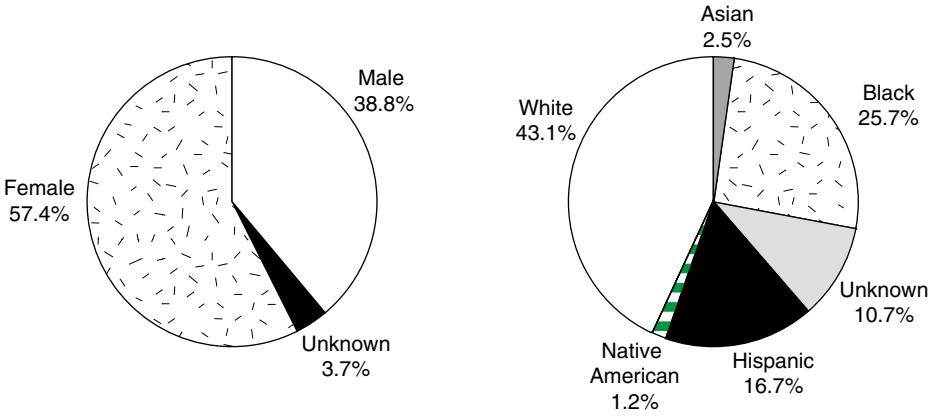
Medicaid Enrollees, by Maintenance Assistance Status: Fiscal Year 1998



SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 4

Medicaid Enrollees, by Sex and Race: Fiscal Year 1998

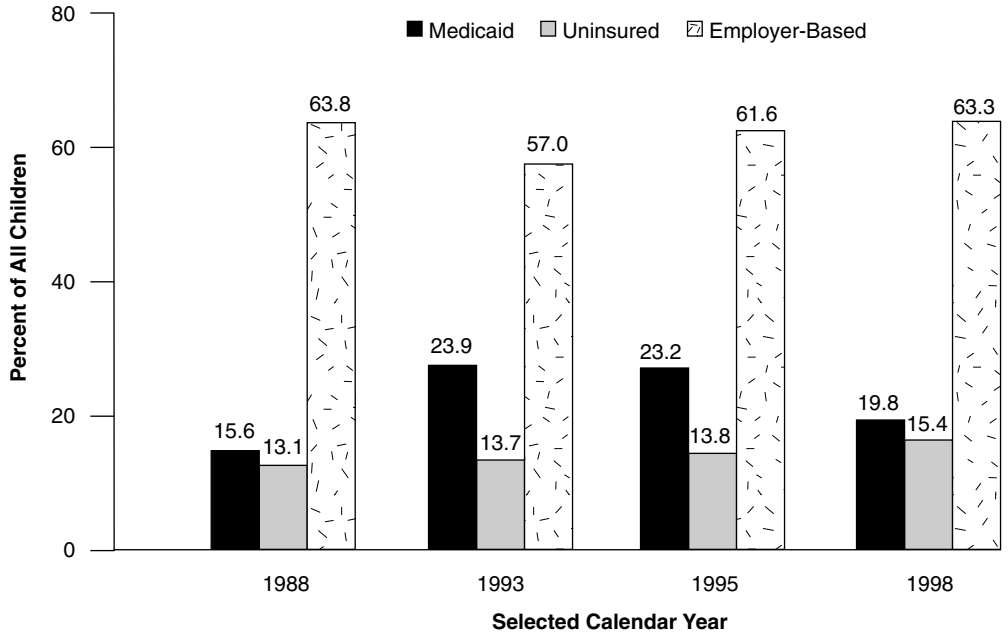


NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 5

Percent of Insurance Children, by Type of Coverage: Selected Calendar Years

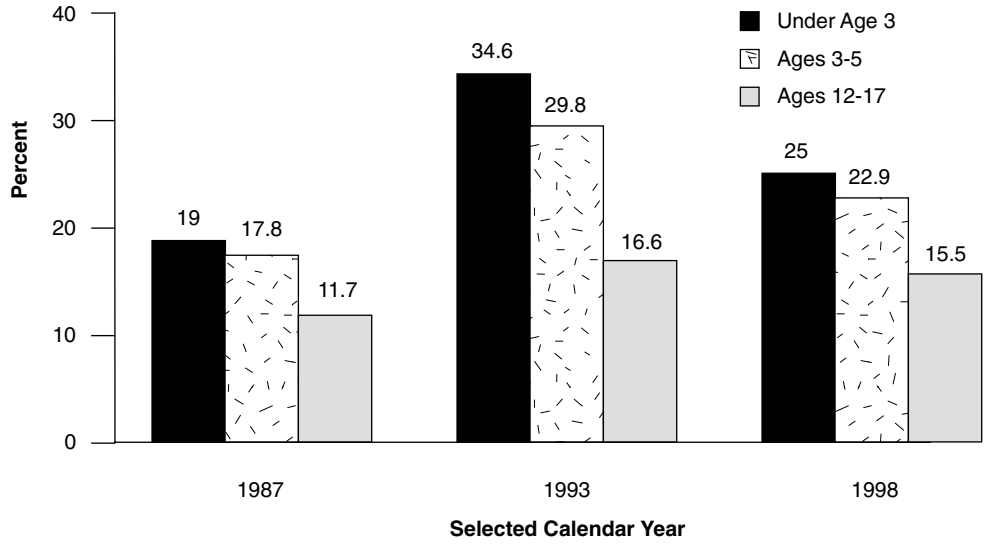


NOTES: Children refers to all people under the age of 18. The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of insurance during the year. In 1994, health insurance questions on the *Current Population Survey* were redesigned; increases in estimates of employment-based coverage may be partially due to questionnaire changes; overall coverage estimates were not affected.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1988, 1993, 1995, and 1998 U.S. Bureau of the Census, March *Current Population Survey*, U.S. Government Printing Office. Washington, DC. 2000.

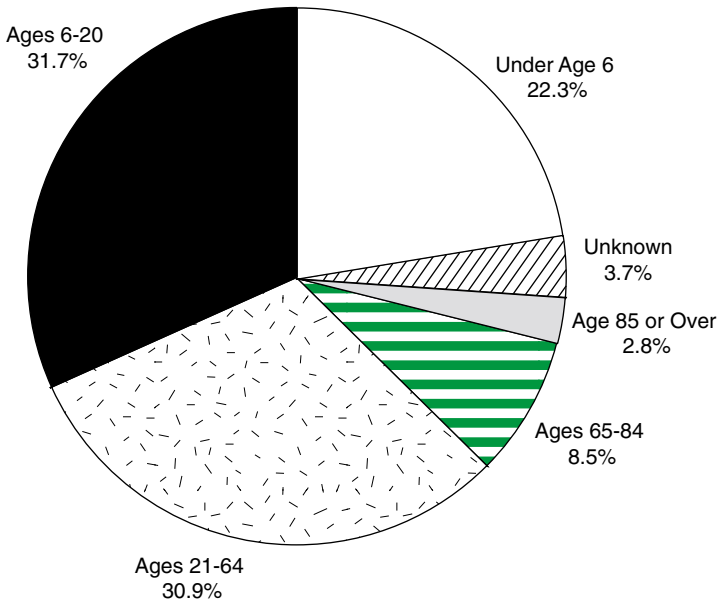
Figure 6

Percent of Children With Medicaid, by Age Groups: Selected Calendar Years



SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1987, 1993, and 1998 U.S. Bureau of the Census, March *Current Population Survey*, U.S. Government Printing Office. Washington, DC. 2000.

Figure 7
Medicaid Enrollees, by Age: Fiscal Year 1998

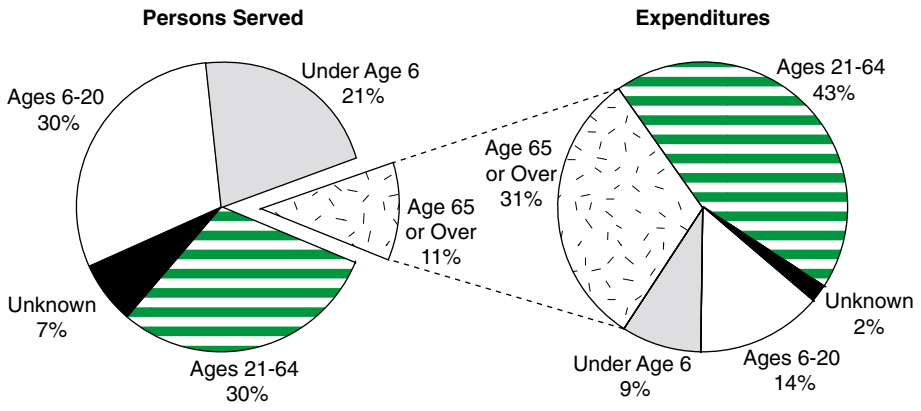


NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 8

Persons Served Through Medicaid and Expenditures, by Age: Fiscal Year 1998

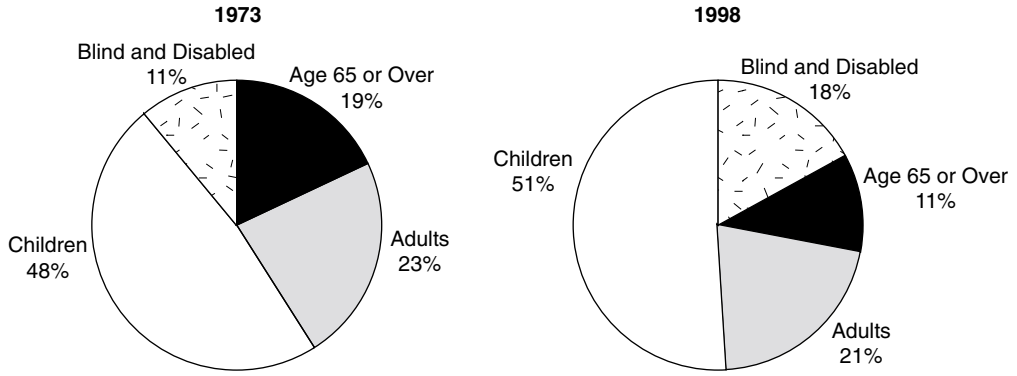


NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 9

Distribution of Persons Served Through Medicaid, by Basis of Eligibility: Fiscal Years 1973 and 1998

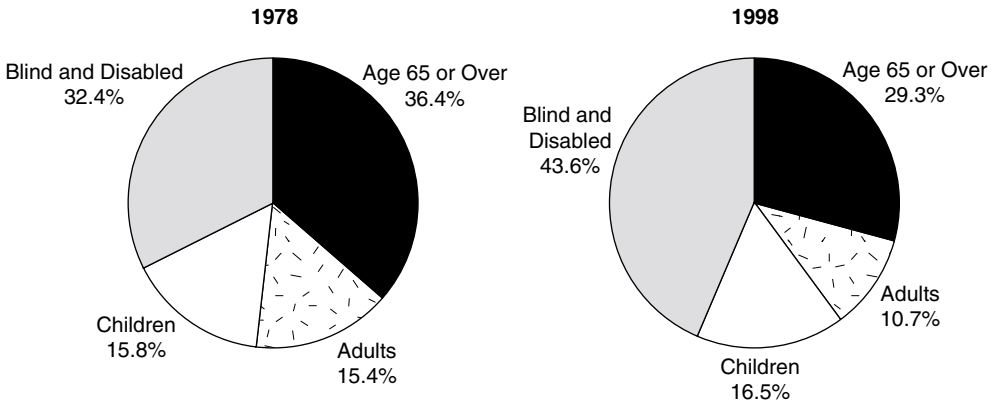


NOTES: The percentage distribution for 1973 does not include 1.5 million persons served by Medicaid whose basis of eligiblity is reported as other, and the percentage distribution for 1998 does not include 3.1 million persons served whose basis of eligibility is unknown. Percentages may not sum to 100 because of rounding. The term adults, refers to a category of non-elderly, non-disabled adults. Disabled children are included in the blind and disabled category.

SOURCE: Health Care Financing Administration, Office of Information Services: Data development by Enterprise Databases Group, data from the 1973 and 1998 HCFA 2082, 2000.

Figure 10

Distribution of Medicaid Payments, by Eligibility Group: Fiscal Years 1978 and 1998

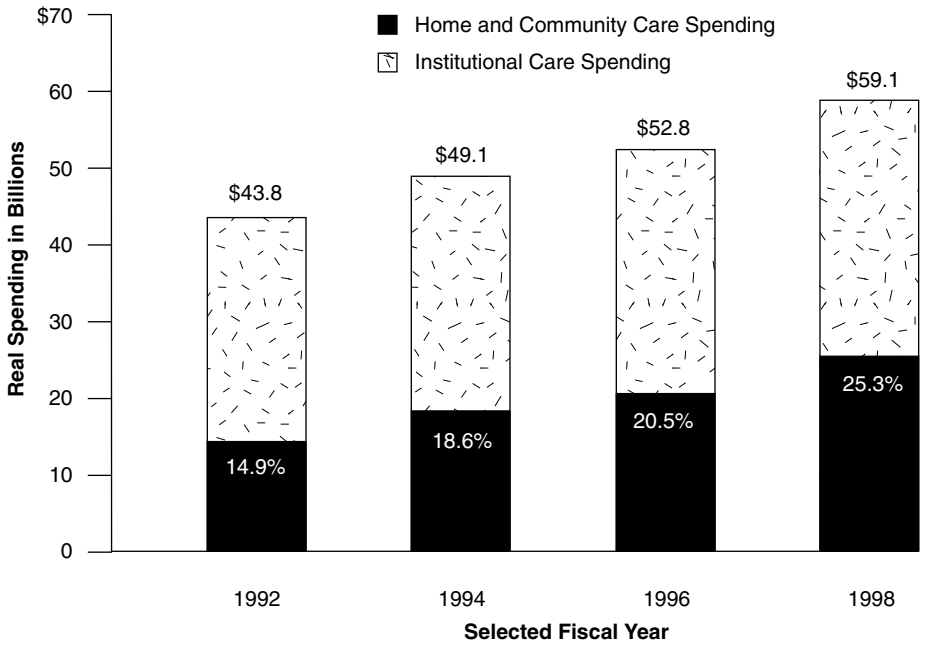


NOTES: The percentage distribution for 1978 does not include $1.4 billion of payments (in 1998 dollars) on behalf of 1.9 million persons served by Medicaid whose basis of eligibility is reported as other, and the percentage distribution for 1998 does not include $3.7 billion on behalf of 3.1 million persons served whose basis of eligibility is unknown. Percentages may not sum to 100 because of rounding. Payments describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude disproportionate share hospital payments, Medicare premiums, and cost sharing on behalf of dual beneficiaries). The term adults as used refers to non-elderly, non-disabled adults. Disabled children are included in the blind and disabled category.

SOURCE: Health Care Financing Administration, Office of Information Services: Data development by Enterprise Databases Group, data from the 1978 and 1998 HCFA 2082, 2000.

Figure 11

Medicaid Spending for Institutional Long-Term Care (LTC) and Home and Community Care, by Selected Fiscal Years

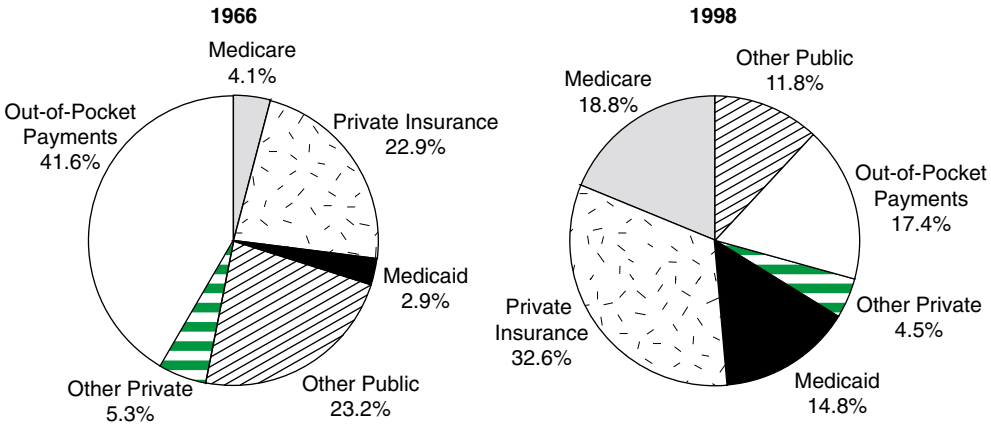


NOTES: The data are expressed in 1998 dollars. Total Medicaid LTC expenditures consist of spending on institutional LTC and home and community care. Institutional LTC spending includes expenditures for nursing facilities, and public and private intermediate care facilities for the mentally retarded. Home and community care spending consists of expenditures for personal care, home health, and home and community-based waivers. The percentages (e.g., 14.9 percent, 18.6 percent, etc.) represent the proportion of total Medicaid LTC spending that is home and community care spending.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1992, 1994, 1996, and 1998 HCFA 64, 2000.

Figure 12

Medicaid Expenditures as a Percent of All National Health Expenditures: Calendar Years 1966 and 1998

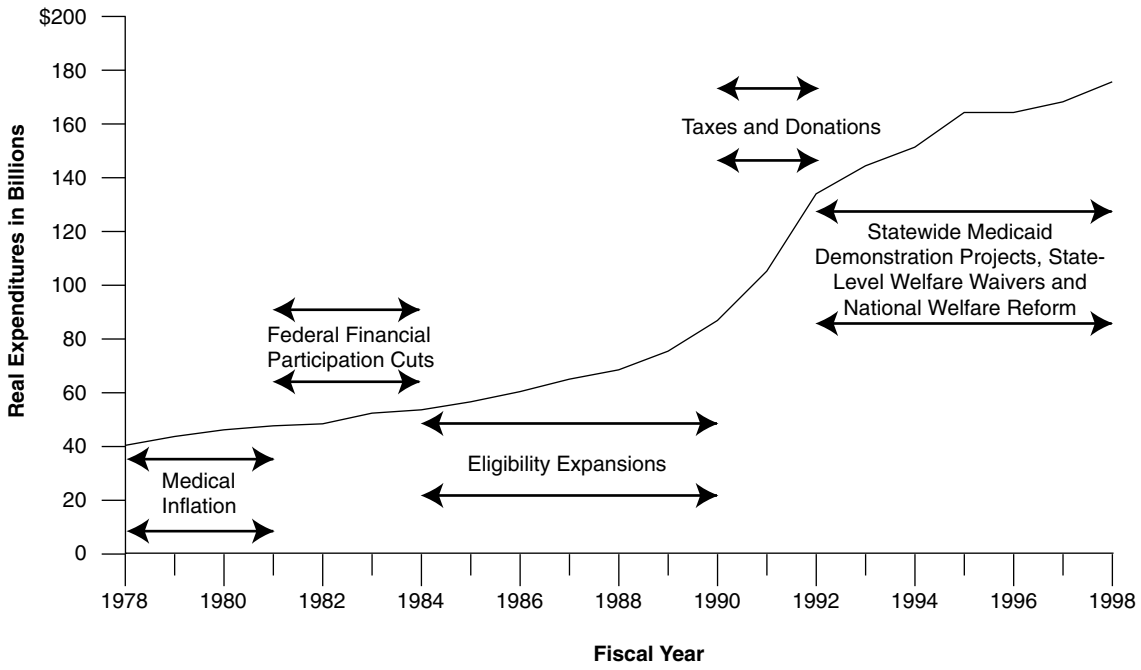


NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the National Health Statistics Group, 2000.

Figure 13

Total Medicaid Spending, by Era: Fiscal Years 1978-1998

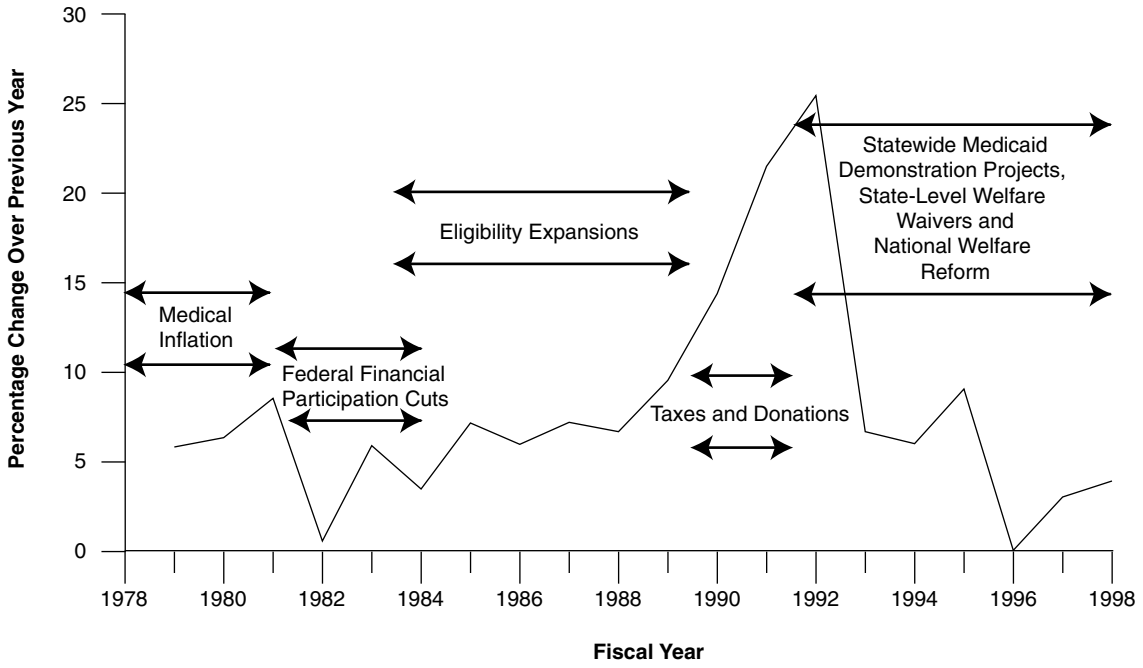


NOTE: The data are expressed in 1998 dollars.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

Figure 14

Percent Change in Total Medicaid Spending in Real Terms, by Era: Fiscal Years 1978-1998

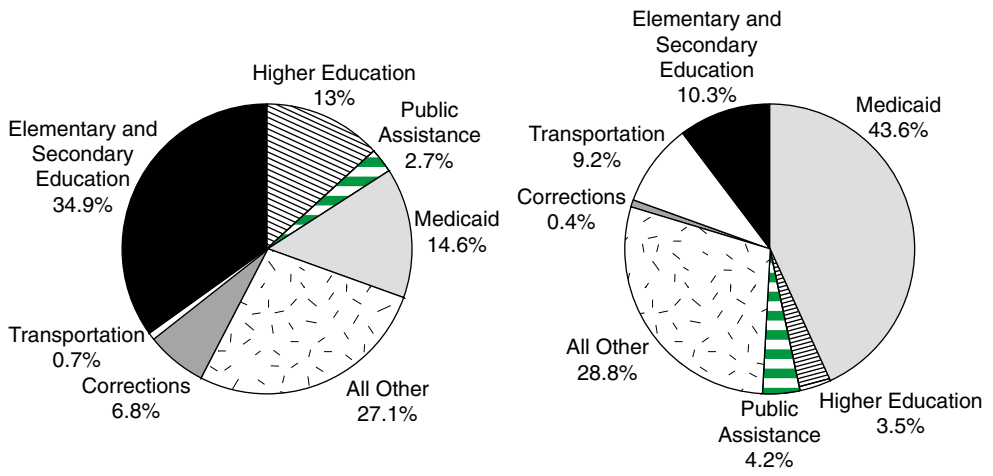


NOTE: The data are expressed in 1998 dollars.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

Figure 15

State Medicaid Spending Compared With Other Expenditures, by Fund Sources: Fiscal Year 1999



State Spending: General Funds

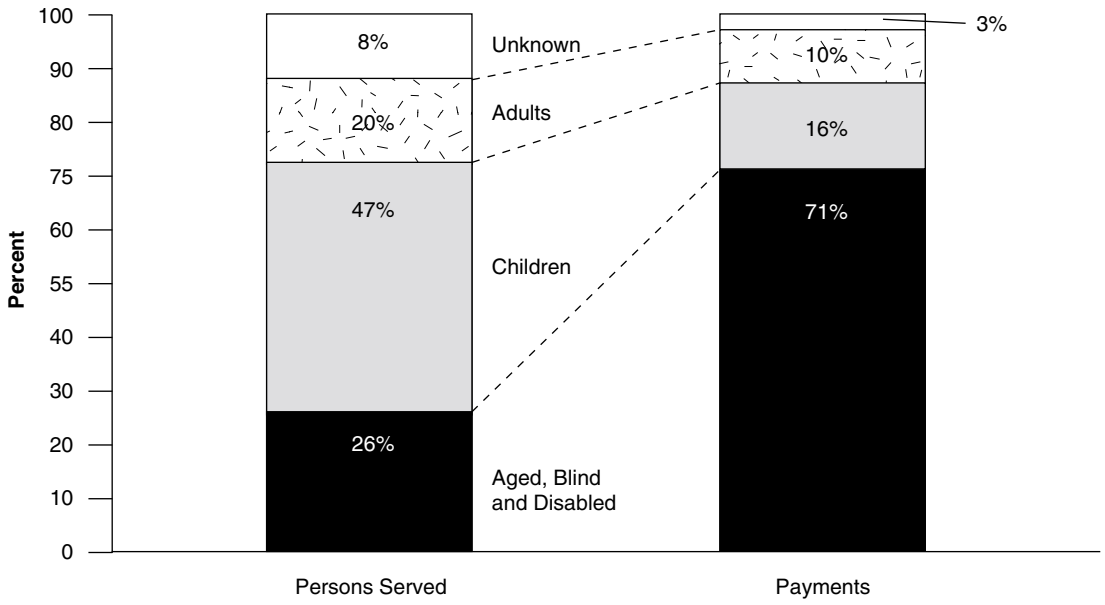
State Spending: Federal Funds Provided to States

NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from the National Association of State Budget Officers, 1999 State Expenditure Report, 2000.

Figure 16

Distribution of Persons Served Through Medicaid and Payments, by Basis of Eligibility: Fiscal Year 1998

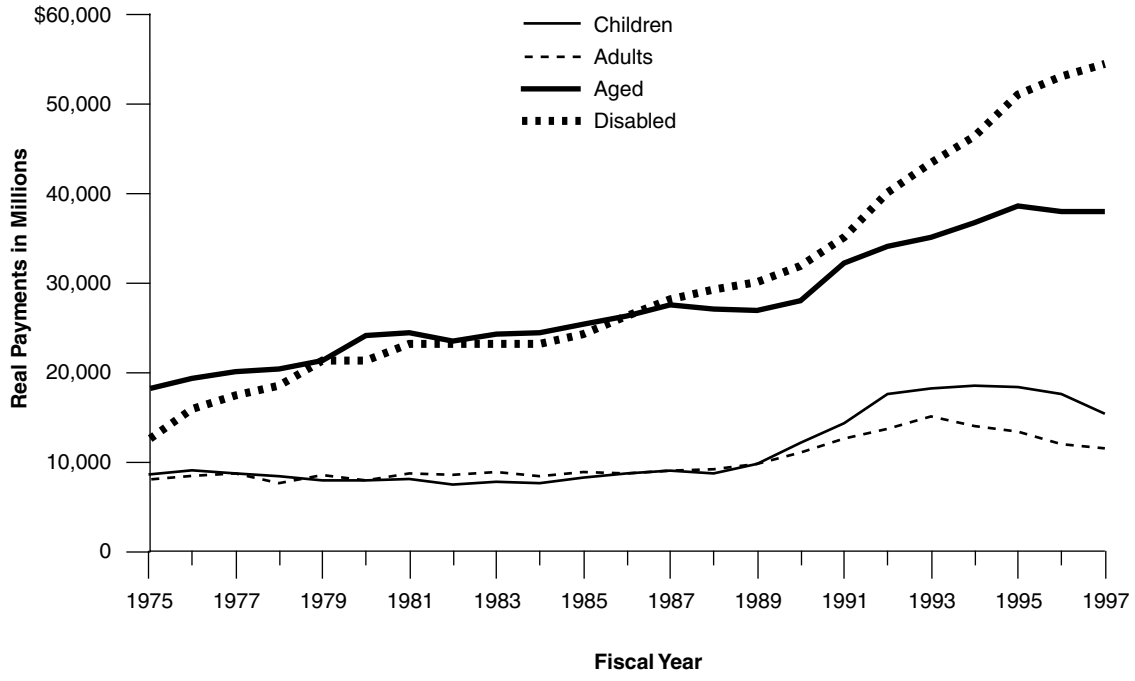


NOTES: Totals may not equal 100 percent because of rounding. Payments describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude disproportionate share hospital payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare). Disabled children are included in the aged, blind and disabled category.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 17

Medicaid Payments, by Eligibility Group: Fiscal Years 1975-1997

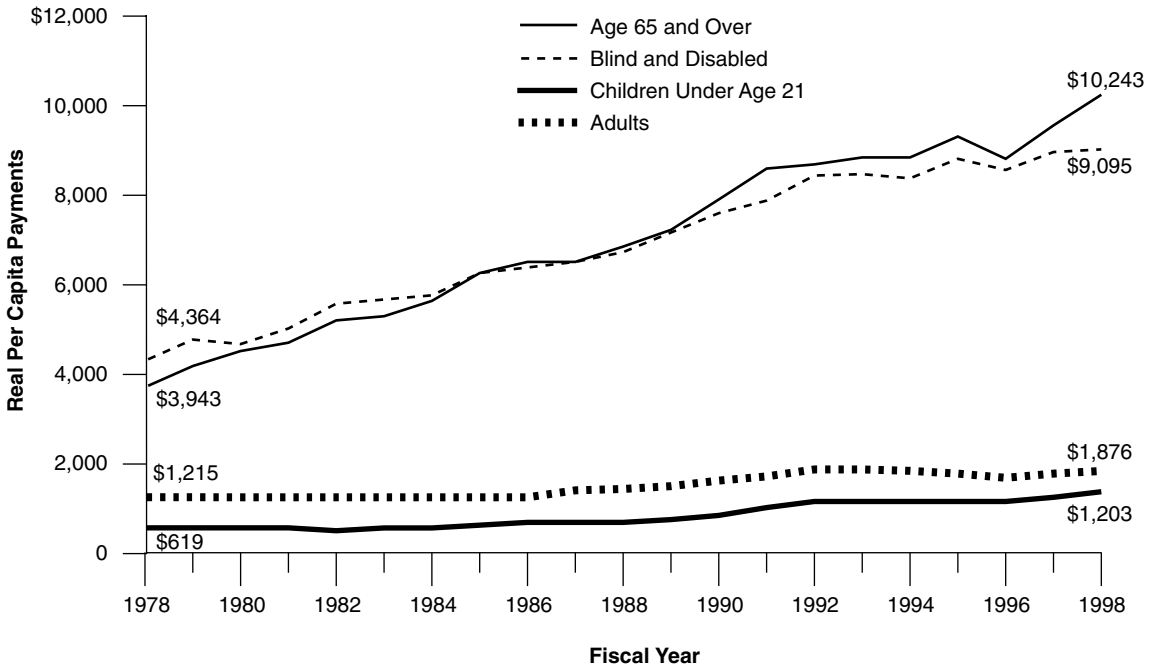


NOTE: Expenditures expressed in 1997 dollars.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Division of Beneficiary Research, data from 1975-1997 HCFA 2082, 2000.

Figure 18

Average Real Medicaid Payments per Person Served: Fiscal Years 1978-1998

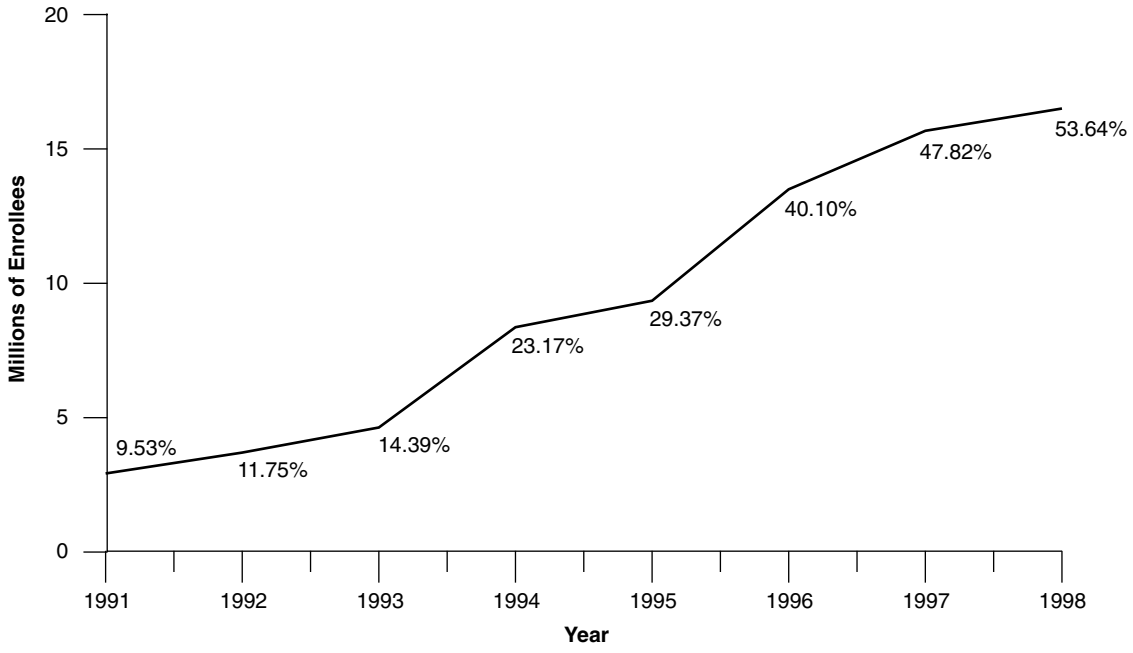


NOTES: Data shown expressed in 1998 dollars. For fiscal year 1998 payments describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude disproportionate share hospital payments, Medicare premiums, and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare), while data from previous years only include direct vendor payments. The term adults as used refers to a category of non-elderly, non-disabled adults. Disabled children are included in the blind and disabled category.

SOURCE: Health Care Financing Administration, Office of Information Services: Data development by Enterprise Databases Group, data from 1978-1998 HCFA 2082, 2000.

Figure 19

Number and Percent of Medicaid Beneficiaries Enrolled in Managed Care, by Year[1]: 1991-1998



[1] June 30 reporting date.

NOTE: State-reported managed care data prior to 1996 may include duplicated enrollment.

SOURCE: Health Care Financing Administration, Center for Medicaid and State Operations: Data from the 1998 Medicaid Managed Care Enrollment Report, 2000.

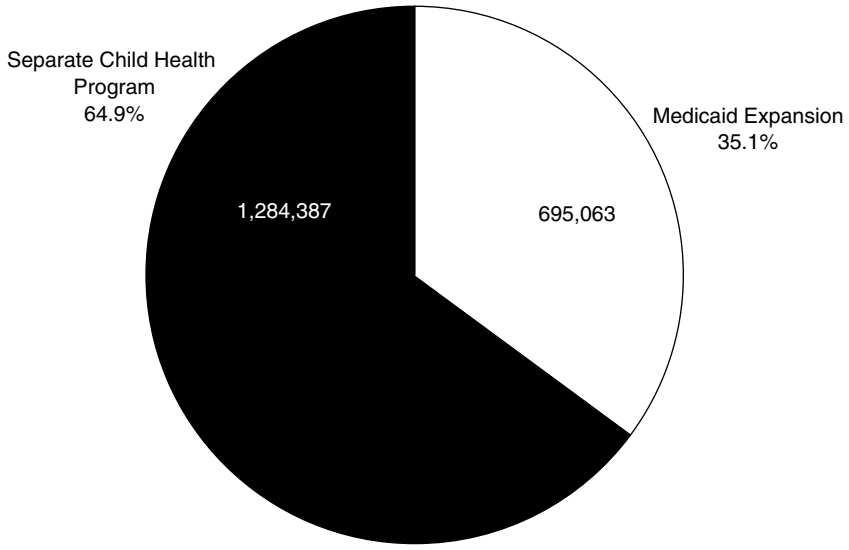
Figure 20
Medicaid Managed Care Penetration, 1998

0 Percent	1-25 Percent	26-50 Percent	51-75 Percent	76-100 Percent
Alaska	Illinois	California	Alabama	Arizona
Virgin Islands	Louisiana	Distict of Columbia	Arkansas	Colorado
Wyoming	Maine	Idaho	Connecticut	Delaware
	New Hampshire	Kansas	Florida	Georgia
	South Carolina	Mississippi	Indiana	Hawaii
	Texas	Missouri	Kentucky	Iowa
		Nevada	Maryland	Montana
		New York	Massachusetts	New Mexico
		Ohio	Michigan	Oregon
		Oklahoma	Minnesota	Puerto Rico
		Vermont	Nebraska	Tennessee
		West Virginia	New Jersey	Utah
		Wisconsin	North Carolina	Washington
			North Dakota	
			Pennsylvania	
			Rhode Island	
			South Dakota	
			Virginia	

SOURCE: Health Care Financing Administration, Center for Medicaid and State Operations: Data from the 1998 Medicaid Managed Care Enrollment Report, 2000.

Figure 21

State Children's Health Insurance Program Enrollment: Fiscal Year 1999



SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from fiscal year 1999 State Children's Health Insurance Program Annual Enrollment Report, 2000.

Overview of the Medicare and Medicaid Programs

Earl Dirk Hoffman, Jr., Barbara S. Klees, A.S.A., and Catherine A. Curtis, Ph.D.

TITLE XVIII AND TITLE XIX OF THE SOCIAL SECURITY ACT

INTRODUCTION

Since early in this century, health insurance coverage has been an important issue in the United States. The first coordinated efforts to establish government health insurance were initiated at the State level between 1915 and 1920. However, these efforts came to naught. Renewed interest in government health insurance surfaced at the Federal level during the 1930s, but nothing concrete resulted beyond the limited provisions in the Social Security Act that supported State activities relating to public health and health care services for mothers and children.

From the late 1930s on, most people desired some form of health insurance to provide protection against unpredictable and potentially catastrophic medical costs. The main issue was whether health insurance should be privately or publicly financed. Private health insurance, mostly group insurance financed through the employment relationship, ultimately prevailed for the great majority of the population.

Private health insurance coverage grew rapidly during World War II, as employee fringe benefits were expanded because the government limited direct wage increases. This trend continued after the war. Concurrently, numerous bills incorporating proposals for national health insurance, financed by payroll taxes, were introduced in Congress during the 1940s; however, none was ever brought to a vote.

Instead, Congress acted in 1950 to improve access to medical care for needy persons who were receiving public assistance. This action permitted, for the first time, Federal participation in the financing of State payments made directly to the providers of medical care for costs incurred by public assistance recipients.

Congress also perceived that aged individuals, like the needy, required improved access to medical care. Views differed, however, regarding the best method for achieving this goal. Pertinent legislative proposals in the 1950s and early 1960s reflected widely different approaches. When consensus proved elusive, Congress passed limited legislation in 1960, including legislation titled "Medical Assistance to the Aged," which provided medical assistance for aged persons who were less poor, yet still needed assistance with medical expenses.

After lengthy national debate, Congress passed legislation in 1965 establishing the Medicare and Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly (with coverage added in 1973 for certain disabled persons and certain persons with kidney disease). Medicaid was

The authors are with the Office of the Actuary (OACT), Health Care Financing Administration (HCFA). The views expressed in this article do not necessarily reflect the policies or legal positions of the Department of Health and Human Services (DHHS) or HCFA.

NOTES: This article provides brief summaries of complex subjects. It should be used only as an overview and general guide to the Medicare and Medicaid programs. This is not a legal document, nor is it intended to fully explain all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs, or of the relationship between these programs. This article does not render any legal, accounting, or other professional advice and should not be relied on in making specific decisions. Only original sources should be utilized.

established in response to the widely perceived inadequacy of welfare medical care under public assistance. Responsibility for administering the Medicare and Medicaid programs was entrusted to the Department of Health, Education, and Welfare—the forerunner of the current DHHS. Until 1977, the Social Security Administration (SSA) managed the Medicare program, and the Social and Rehabilitation Service (SRS) managed the Medicaid program. The duties were then transferred from SSA and SRS to the newly formed HCFA.

NATIONAL HEALTH CARE EXPENDITURES

HISTORICAL OVERVIEW

Health spending in the United States has grown rapidly over the past few decades. From $27 billion in 1960, it grew to $898 billion in 1993, increasing at an average rate of more than 11 percent annually. This strong growth boosted health care's role in the overall economy, with health expenditures rising from 5.1 percent to 13.7 percent of the gross domestic product (GDP) between 1960 and 1993.

During the last 6 years, however, strong growth trends in health care spending have subsided. Health spending rose at a 5-percent average annual rate between 1993 and 1998 to reach $1.1 trillion. Similarly, the share of GDP going to health care stabilized, with the 1998 share measured at 13.5 percent. This trend reflects the nexus of several factors: the movement of most workers insured for health care through employer-sponsored plans to lower-cost managed care; low general and medical-specific inflation; and excess capacity among some health service providers, which boosted competition among providers to be included in managed care plans and drove down prices. For the 281 million people residing in the United States, the average expenditure for health care in 1998 was $4,094 per person, up from $141 in 1960.

Health care is funded through a variety of private payers and public programs. Privately funded health care includes individuals' out-of-pocket expenditures, private health insurance, philanthropy, and non-patient revenues (such as gift shops and parking lots), as well as health services that are provided in industrial settings. For the years 1974-1991, these private funds paid for 58 to 60 percent of all health care costs. By 1997, however, the private share of health costs had declined to 53.8 percent of the country's total health care expenditures, rising slightly to 54.5 percent in 1998. The share of health care provided by public spending increased correspondingly during the 1992-1997 period, falling slightly in 1998.

Public spending represents expenditures by Federal, State, and local governments. Of the publicly funded health care costs for the United States, each of the following accounts for a small percentage of the total: the Department of Defense health care programs for military personnel, the Department of Veterans' Affairs health programs, non-commercial medical research, payments for health care under Workers' Compensation programs, health programs under State-only general assistance programs, and the construction of public medical facilities. Other activities that are also publicly funded include: maternal and child health services, school health programs, public health clinics, Indian health care services, migrant health care services, substance abuse and mental health activities, and medically related vocational rehabilitation services. The largest shares of public health expenditures, however, are made by the Medicare and Medicaid programs.

Together, Medicare and Medicaid financed $387 billion in health care services in 1998—about one-third of the country's total

health care bill and almost three-fourths of all public spending on health care. Since their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements in the provision of health care services to our Nation's aged, disabled, and disadvantaged.

PROJECTED EXPENDITURES

National health expenditures (NHE) are projected to total $2.2 trillion in 2008, growing at an average annual rate of 6.5 percent from their level in 1997. Following the sustained plateau in health care's share of GDP for 1993-1997 (at 13.5-13.7 percent), health care is expected to increase to 16.2 percent of GDP by 2008. This trend is likely to place renewed pressure on private- and public-sector payers to search for additional ways to constrain cost growth.

Three principal patterns of growth characterize these projections: (1) a rising share of GDP devoted to health care, but at a rate of increase below that experienced for 1960-1992; (2) a cyclical pattern of growth in private spending, with accelerating growth for 1998-2001 and decelerating growth for 2002-2008; and (3) diverging patterns of growth in private and public spending for 1998-2002 as the implementation of the Balanced Budget Act of 1997 (BBA) restrains growth in Medicare spending.

Due to the implementation of provisions of the BBA and heightened efforts to investigate Medicare fraud and abuse, public spending on health care in 1998 exhibited its slowest pace of growth on record since 1960. The pattern of slower growth in public, relative to private, spending is expected to continue through 2002 as the provisions of the BBA are implemented. Beyond that point, Medicare spending is likely to accelerate, while growth in private spending is expected to slow through 2008.

The overall result is that Medicare is projected to stabilize as a share of national health spending between 2001 and 2008, while private spending falls from 55.2 percent to 53.6 percent of national health spending, thus reversing the anticipated effects of the 1997-2001 period. The projections for spending on medical services include a deceleration in drug spending growth, a slowdown in the movement of services out of acute care, and a significant slowdown in spending growth for nursing home and other extended care.

MEDICARE

OVERVIEW

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled," is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise non-covered aged persons who elect to pay a premium for Medicare coverage.

For further information on NHE accounts and projections, Medicare data, and Medicaid data, refer to the OACT/HCFA internet website, "Actuarial Publications and Data" at www.hcfa.gov/pubforms/actuary/. NHE estimates are from the National Health Statistics Group, OACT, HCFA. Medicare enrollment data are based on estimates prepared for the 2000 Annual Report of the Medicare Board of Trustees to Congress. Medicaid data are based on the projections of the Mid-Session Review of the President's Fiscal Year 2001 Budget.

Medicare has traditionally consisted of two parts: hospital insurance (HI), also known as Part A, and supplementary medical insurance (SMI), also known as Part B. A new, third part of Medicare, sometimes known as Part C, is the Medicare+Choice program, which was established by the BBA (Public Law 105-33) and which expanded beneficiaries' options for participation in private-sector health care plans. When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2000, about 40 million people are enrolled in one or both of Parts A and B of the Medicare program, and 6.4 million of them have chosen to participate in a Medicare+Choice plan.

COVERAGE

HI is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in Federal, State, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are entitled to HI benefits. HI coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly premium for their coverage. In 1999, the HI program provided protection against the costs of hospital and specific other medical care to about 39 million people (34 million aged and 5 million disabled enrollees). HI benefit payments totaled $129 billion in 1999.

The following health care services are covered under Medicare's HI program:

- *Inpatient hospital* care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care (LTC) hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required of beneficiaries who are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).
- *Skilled nursing facility* (SNF) care is covered by HI only if it follows within 30 days (generally) of a hospitalization of 3 days or more and is certified as medically necessary. Covered services are similar to those for inpatient hospital but also include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (described later), with a copayment required for days 21-100. HI does not cover nursing facility care if the patient does not require skilled nursing or skilled rehabilitation services.
- *Home health agency* (HHA) care, including care provided by a home health aide, may be furnished part-time by a HHA in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment (DME) may also be provided.

There must be a plan of treatment and periodical review by a physician. Home health care under HI has no duration limitations, no copayment, and no deductible. For DME, beneficiaries must pay a 20-percent coinsurance, as required under SMI of Medicare. Full-time nursing care, food, blood, and drugs are not provided as HHA services. The BBA transferred from HI to SMI those home health services furnished on or after January 1, 1998 that are unassociated with a hospital or skilled nursing facility stay. HI will continue to cover the first 100 visits following a 3-day hospital stay or a skilled nursing facility stay. The cost of the transferred services is being gradually shifted from HI to SMI over a 6-year period. A portion of the higher SMI costs is gradually included in the monthly SMI premium paid by beneficiaries over 7 years (1998-2003).

- *Hospice* care is a service provided to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program, but does pay small coinsurance amounts for drugs and inpatient respite care.

An important HI component is the benefit period, which starts when the beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by HI during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61-90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can elect to use days of Medicare coverage from a non-renewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care. Copayments are also required for such additional days.

All citizens (and certain legal aliens) age 65 or over, and all disabled persons entitled to coverage under HI, are eligible to enroll in the SMI program on a voluntary basis by payment of a monthly premium. Almost all persons entitled to HI choose to enroll in SMI. In 1999, the SMI program provided protection against the costs of physician and other medical services to about 37 million people. SMI benefits totaled $80.7 billion in 1999.

The SMI program covers the following services and supplies:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists. Also covered are the services provided by these Medicare-approved practitioners who are not physicians: certified registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or SNF), physician assistants, and nurse practitioners and clinical nurse specialists in collaboration with a physician.
- Services in an emergency room or outpatient clinic, including same-day surgery, and ambulance services.
- Home health care not covered under HI.

- Laboratory tests, X-rays, and other diagnostic radiology services, as well as certain preventive care screening tests.
- Ambulatory surgical center services in a Medicare-approved facility.
- Most physical and occupational therapy and speech pathology services.
- Comprehensive outpatient rehabilitation facility services, and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it.
- Radiation therapy, renal (kidney) dialysis and transplants, and heart and liver transplants under certain limited conditions.
- Approved DME for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, and casts.
- Drugs and biologicals that cannot be self-administered, such as hepatitis B vaccines and immunosuppressive drugs (certain self-administered anticancer drugs are covered).

To be covered, all services must be either medically necessary or one of several prescribed preventive benefits. SMI services are generally subject to a deductible and coinsurance (described later). Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical or occupational therapy services performed after 2001 in settings other than hospitals), and higher cost-sharing requirements (such as those for outpatient treatments for mental illness).

It should be noted that some health care services are not covered by Medicare. Noncovered services include long-term nursing care, custodial care, and certain other health care needs, such as dentures and dental care, eyeglasses, hearing aids, and most prescription drugs. These services are not a part of the Medicare program unless they are a part of a private health plan under the Medicare+Choice program.

Medicare+Choice (Part C) is an expanded set of options for the delivery of health care under Medicare. While all Medicare beneficiaries can receive their benefits through the original fee-for-service (FFS) program, most beneficiaries enrolled in both HI and SMI can choose to participate in a Medicare+Choice plan instead. Organizations that seek to contract as Medicare+Choice plans must meet specific organizational, financial, and other requirements. Following are the primary Medicare+Choice plans:

- Coordinated care plans, which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law.
- Private, unrestricted FFS plans, which allow beneficiaries to select certain private providers. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor does it vary payment rates based on utilization.
- Medical savings account (MSA) plans, which provide benefits after a single high deductible is met. Medicare makes an annual deposit to the MSA, and the beneficiary is expected to use the money in the MSA to pay for medical expenses below the annual deductible. MSAs are currently a test program for a limited number of eligible Medicare beneficiaries.

Except for MSA plans, all Medicare+Choice plans are required to provide at least the current Medicare benefit package, excluding hospice services. Plans may offer additional covered

services and are required to do so (or return excess payments) if plan costs are lower than the Medicare payments received by the plan. There are some restrictions as to who may elect an MSA plan, even when enrollment is no longer limited to a certain number of participants.

PROGRAM FINANCING, BENEFICIARY LIABILITIES, AND PROVIDER PAYMENTS

All financial operations for Medicare are handled through two trust funds, one for the HI program and one for the SMI program. These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

PROGRAM FINANCING

The HI program is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by the HI program and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The HI tax rate is 1.45 percent of earnings, to be paid by each employee and a matching amount by the employer for each employee, and 2.90 percent for self-employed persons. Beginning in 1994, this tax is paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) The HI tax rate is specified in the Social Security Act and cannot be changed without legislation.

The HI trust fund also receives income from the following sources: (1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries; (2) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily; (3) reimbursements from the general fund of the U.S. Treasury for the cost of providing HI coverage to certain aged persons who retired when the HI program began and thus were unable to earn sufficient quarters of coverage (and those Federal retirees similarly unable to earn sufficient quarters of Medicare-qualified Federal employment); (4) interest earnings on its invested assets; and (5) other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

The SMI program is financed through premium payments ($45.50 per beneficiary per month in 2000) and contributions from the general fund of the U.S. Treasury. Beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Therefore, the contributions from the general fund of the U.S. Treasury are the largest source of SMI income. The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. Beneficiary premiums and general fund payments are redetermined annually, to match estimated program costs for the following year.

Capitation payments to Medicare+Choice plans are financed from the HI and SMI trust funds in proportion to the relative weights of HI and SMI benefits to the total benefits paid by the Medicare program.

BENEFICIARY PAYMENT LIABILITIES

FFS beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of both HI and SMI. These liabilities may be paid (1) by the Medicare beneficiary; (2) by a third party, such as an employer-sponsored retiree health plan or private "medigap" insurance; or (3) by Medicaid, if the person is eligible. The term medigap is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by Blue Cross and Blue Shield (BC/BS) and various commercial health insurance companies.

For beneficiaries enrolled in Medicare+Choice plans, the beneficiary's payment share is based on the cost-sharing structure of the specific plan selected by the beneficiary, since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of FFS beneficiaries. Such beneficiaries pay the monthly Part B premium and may, depending upon the plan, pay an additional plan premium.

For hospital care covered under HI, a FFS beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($776 in 2000). This deductible covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($194 per day in 2000) are required through the 90th day of a benefit period. Each HI beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments ($388 per day in 2000) are required.

For skilled nursing care covered under HI, Medicare fully covers the first 20 days of SNF care in a benefit period. But for days 21-100, a copayment ($97 per day in 2000) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or coinsurance payment by the beneficiary. In any HI service, the beneficiary is responsible for fees to cover the first 3 pints or units of nonreplaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by the HI program. Eligibility is generally earned through the work experience of the beneficiary or of his or her spouse. However, most aged people who are otherwise ineligible for premium-free HI coverage can enroll voluntarily by paying a monthly premium, if they also enroll in SMI. For people with fewer than 30 quarters of coverage as defined by SSA, the 2000 HI monthly premium rate is $301; for those with 30 to 39 quarters of coverage, the rate is reduced to $166. Voluntary coverage upon payment of the HI premium, with or without enrolling in SMI, is also available to disabled individuals for whom cash benefits have ceased due to earnings in excess of those allowed for receiving cash benefits.

For SMI, the beneficiary's payment share includes the following: one annual deductible (currently $100); the monthly premiums; the coinsurance payments for SMI services (usually 20 percent of the medically allowed charges); a deductible for blood; certain charges above the Medicare-allowed charge (for claims not on assignment); and payment for any services that

are not covered by Medicare. For outpatient mental health treatment services, the beneficiary is liable for 50 percent of the approved charges.

PROVIDER PAYMENTS

For HI, before 1983, payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under PPS, a specific predetermined amount is paid for each inpatient hospital stay, based on each stay's diagnosis-related group (DRG) classification. In some cases the payment the hospital receives is less than the hospital's actual cost for providing the HI-covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays. Payments for skilled nursing care are made under a separate PPS. Payments for inpatient rehabilitation, psychiatric, and home health care are currently reimbursed on a reasonable cost basis, but PPSs are expected to be implemented in the near future, as required by the BBA.

For SMI, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of (1) the physician's actual charge; (2) the physician's customary charge; or (3) the prevailing charge for similar services in that locality. Beginning January 1992, allowed charges were defined as the lesser of (1) the submitted charges, or (2) the amount determined by a fee schedule based on a relative value scale (RVS). Payments for DME and clinical laboratory services are also based on a fee schedule. Hospital outpatient services and HHAs are currently reimbursed on a reasonable cost basis, but the BBA has provided for implementation of a PPS for these services in the near future.

If a doctor or supplier agrees to accept the Medicare-approved rate as payment in full (takes assignment), then payments provided must be considered as payments in full for that service. The provider may not request any added payments (beyond the initial annual deductible and coinsurance) from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by medigap insurance). Limits now exist on the excess that doctors or suppliers can charge. Physicians are participating physicians if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since Medicare beneficiaries may select their doctors, they have the option to choose those who participate.

Medicare payments to Medicare+Choice plans are based on a blend of local and national capitated rates, generally determined by the capitation payment methodology described in Section 1853 of the Social Security Act. Actual payments to plans vary based on demographic characteristics of the enrolled population. New risk adjusters based on demographics and health status are currently being phased in to better match Medicare capitation payments to the expected costs of individual beneficiaries.

MEDICARE CLAIMS PROCESSING

Medicare's HI and SMI FFS claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal Government. These claims processors are known as intermediaries and carriers. They apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare intermediaries process HI claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. They also process outpatient hospital claims for SMI. Examples of intermediaries are BC/BS (which utilize their plans in various States) and other commercial insurance companies. Intermediaries' responsibilities include the following:

- Determining costs and reimbursement amounts.
- Maintaining records.
- Establishing controls.
- Safeguarding against fraud and abuse or excess use.
- Conducting reviews and audits.
- Making the payments to providers for services.
- Assisting both providers and beneficiaries as needed.

Medicare carriers handle SMI claims for services by physicians and medical suppliers. Examples of carriers are the BS plans in a State, and various commercial insurance companies. Carriers' responsibilities include the following:

- Determining charges allowed by Medicare.
- Maintaining quality-of-performance records.
- Assisting in fraud and abuse investigations.
- Assisting both suppliers and beneficiaries as needed.
- Making payments to physicians and suppliers for services that are covered under SMI.

Peer review organizations (PROs) are groups of practicing health care professionals who are paid by the Federal Government to generally oversee the care provided to Medicare beneficiaries in each State and to improve the quality of services. PROs educate other health care professionals and assist in the effective, efficient, and economical delivery of health care services to the Medicare population. The ongoing effort to combat monetary fraud and abuse in the Medicare program was intensified after enactment of the Health Insurance Portability and Accountability Act of 1996, which created the Medicare Integrity Program. Prior to this 1996 legislation, HCFA was limited by law to contracting with its current carriers and fiscal intermediaries to perform payment safeguard activities. The Medicare Integrity Program provided HCFA with stable, increasing funding for payment safeguard activities, as well as new authorities to contract with entities to perform specific payment safeguard functions.

ADMINISTRATION

DHHS has the overall responsibility for administration of the Medicare program. Within DHHS, responsibility for administering Medicare rests with HCFA. SSA assists, however, by initially determining an individual's Medicare entitlement, by withholding Part B premiums from the Social Security benefit checks of beneficiaries, and by maintaining Medicare data on the master beneficiary record, which is SSA's primary record of beneficiaries. The Internal Revenue Service in the Department of the Treasury collects the HI payroll taxes from workers and their employers.

A Board of Trustees, composed of two appointed members of the public and four members who serve by virtue of their positions in the Federal Government, oversees the financial operations of the HI and SMI trust funds. The Secretary of the Treasury is the managing trustee. The Board of Trustees reports to Congress on the financial and actuarial status of the Medicare trust funds on or about the first day of April each year.

State agencies (usually State Health Departments under agreements with HCFA) identify, survey, and inspect provider and supplier facilities and institutions wishing to participate in the Medicare program. In consultation with HCFA, these agencies then certify the facilities that are qualified.

DATA SUMMARY

The Medicare program covers 95 percent of our Nation's aged population, as well as many people who are on Social Security because of disability. In 1999, HI covered about 39 million enrollees with benefit payments of $128.8 billion, and SMI covered 37 million enrollees with benefit payments of $80.7 billion. Administrative costs were about 1 percent of HI and about 2 percent of SMI disbursements for 1999. Total disbursements for Medicare in 1999 were $213 billion.

MEDICAID

OVERVIEW

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, Medicaid eligibility and/or services within a State can change during the year.

BASIS OF ELIGIBILITY AND MAINTENANCE ASSISTANCE STATUS

Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the Federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the following designated groups. Low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels (as determined by each State within Federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, States are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most States

have additional State-only programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for State-only programs. The following enumerates the mandatory Medicaid categorically needy eligibility groups for which Federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996, or—at State option—more liberal criteria.
- Children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL).
- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).
- Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL (this process phases in coverage, so that by the year 2002 all such poor children under age 19 will be covered).
- Certain Medicare beneficiaries (described later).

States also have the option of providing Medicaid coverage for other categorically related groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which States will receive Federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each State).
- Children under age 21 who meet the AFDC income and resources requirements that were in effect in their State on July 16, 1996.
- Institutionalized individuals eligible under a special income level (the amount is set by each State up to 300 percent of the SSI Federal benefit rate).
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
- Recipients of State supplementary income payments.
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs).
- Optional targeted low-income children included within the State Children's Health Insurance Program (SCHIP) established by the BBA 1997.
- Medically needy (MN) persons (described later).

The MN option allows States to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. Persons may qualify immediately or may spend down by incurring medical expenses that reduce their income to or below their State's MN income level.

Medicaid eligibility and benefit provisions for the MN do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a State elects to have a MN program, there are Federal requirements that certain groups and certain services must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A State may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services within its MN program. Currently, 38 States have elected to have a MN program and are providing at least some MN services to at least some MN recipients. All remaining States utilize the special income level option to extend Medicaid to the near poor in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) ~~k~~known as the welfare reform bill ~~m~~made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are State options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of the new restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstituted by Public Law 105-33, the BBA.

In addition, welfare reform repealed the open-ended Federal entitlement program known as AFDC and replaced it with Temporary Assistance for Needy Families (TANF), which provides States with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits States to impose a wide range of other requirements as well ~~in~~ particular, those related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

Title XXI of the Social Security Act, known as SCHIP, is a new program initiated by the BBA. In addition to allowing States to craft or expand an existing State insurance program, SCHIP provides more Federal funds for States to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assis-

tance to children during a presumptive eligibility period for Medicaid. This is one of several options from which States may select to provide health care coverage for more children, as prescribed within the BBA's Title XXI program.

Medicaid coverage may begin as early as the third month prior to application if the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows States to provide 12 months of continuous Medicaid coverage (without re-evaluation) for eligible children under the age of 19.

SCOPE OF SERVICES

Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons age 21 or over.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and X-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive Federal matching funds to provide certain optional services. Following are the most common of the 34 currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facilities for the mentally retarded (ICFs/MR).
- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Home and community-based care to certain persons with chronic impairments.

The BBA included a State option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons age 55 or over who require a nursing facility level of care. The PACE team offers and manages all health, medical, and social services and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both Titles XVIII and

XIX, without amount, duration, or scope limitations and without application of any deductibles, copayments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

AMOUNT AND DURATION OF SERVICES

Within broad Federal guidelines and certain limitations, States determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, States are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under Federal law, must be covered even if those services are not included as part of the covered services in that State's plan; and (2) States may request waivers to pay for otherwise uncovered home and community-based services for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, States have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, States may not provide room and board for the recipients). With certain exceptions, a State's Medicaid program must allow recipients to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

PAYMENT FOR SERVICES

Medicaid operates as a vendor payment program. States may pay health care providers directly on a FFS basis, or States may pay for Medicaid services through various prepayment arrangements, such as HMOs. Within federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income or uninsured persons under what is known as the disproportionate share hospital (DSH) adjustment. During 1988-1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing Federal expenditures for Medicaid. However, under legislation passed in 1991, 1993, and again within the BBA 1997, the Federal share of payments to DSH hospitals has become increasingly limited.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. The following Medicaid recipients, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid recipients must be ex-

empt from copayments for emergency services and family planning services.

The Federal Government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In 2000, the FMAPs varied from 50 percent in 10 States to 76.80 percent in Mississippi, and averaged 57 percent overall. The BBA also permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent and raised the FMAP for Alaska from 50 percent to 59.8 percent only through 2000. For the children added to Medicaid through the SCHIP program, the FMAP average for all States is about 70 percent, compared with the general Medicaid average of 57 percent.

The Federal Government also reimburses States for 100 percent of the cost of services provided through facilities of the Indian Health Service, provides financial help to the 12 States that furnish the highest number of emergency services to undocumented aliens, and shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the SCHIP program and the qualifying individual (QI) program (described later), Federal payments to States for medical assistance have no set limit (cap). Rather, the Federal Government matches (at FMAP rates) State expenditures for the mandatory services, as well as for the optional services that the individual State decides to cover for eligible recipients, and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

SUMMARY AND TRENDS

Medicaid was initially formulated as a medical care extension of federally-funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures, although the rate of increase has subsided somewhat recently. This rapid growth in Medicaid expenditures has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of Federal mandates, population growth, and the earlier economic recession. In recent years Medicaid enrollment has declined somewhat.
- The expanded coverage and utilization of services.
- The DSH payment program, coupled with its inappropriate use to increase Federal payments to States.

- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very low-birthweight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care.
- The increase in payment rates to providers of health care services, when compared with general inflation.

As with all health insurance programs, most Medicaid recipients require relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. The data for 1998, for example, indicate that Medicaid payments for services for 20.6 million children, who constitute 51 percent of all Medicaid recipients, average about $1,150 per child (a relatively small average expenditure per person). Similarly, for 8.6 million adults, who comprise 21 percent of recipients, payments average about $1,775 per person. However, certain other specific groups have much larger per-person expenditures. Medicaid payments for services for 4 million aged, constituting 11 percent of all Medicaid recipients, average about $9,700 per person; for 7.2 million disabled, who comprise 18 percent of recipients, payments average about $8,600 per person. When expenditures for these high- and lower-cost recipients are combined, the 1998 payments to health care vendors for 40.6 million Medicaid recipients average $3,500 per person.

LTC is an important provision of Medicaid that will be increasingly utilized as our Nation's population ages. The Medicaid program has paid for almost 45 percent of the total cost of care for persons using nursing facility or home health services in recent years. However, for those persons who use more than 4 months of this LTC, Medicaid pays for a much larger percentage. The data for 1998 show that Medicaid payments for nursing facility services (excluding ICFs/MR) and home health care totaled $41.3 billion for more than 3.3 million recipients of these services ~~an~~ average 1998 expenditure of $12,375 per LTC recipient. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for LTC is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional FFS system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided States a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 54 percent in 1998.

Medicaid data as reported by the States indicate that more than 41.0 million persons received health care services through the Medicaid program in 1999. Total outlays for the Medicaid program in 1999 included: direct payment to providers of $133.8 billion, payments for various premiums (for HMOs, Medicare, etc.) of $31.2 billion, payments to DSHs of $15.5 billion, and administrative costs of $9.5 billion.

The total expenditure for the Nation's Medicaid program in 1999, excluding administrative costs, was $180.9 billion ($102.5 billion in Federal and $78.4 billion in State funds). With anticipated impacts from the BBA, projections now are that total Medicaid outlays may be $285 billion in fiscal year 2005, with an additional $6 billion expected to be spent for the new SCHIP.

MEDICAID-MEDICARE RELATIONSHIP

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their State's Medicaid program, according to eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the payer of last resort.

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid program. Qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the HI and SMI premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the SMI premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to the Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare HI and SMI coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their HI premiums as Qualified Disabled and Working Individuals (QDWIs). According to HCFA estimates, Medicaid currently provides some level of supplemental health coverage for 5 million Medicare beneficiaries within the prior three categories.

For Medicare beneficiaries with incomes that are above 120 percent and less than 175 percent of the FPL, the BBA establishes

a capped allocation to States, for each of the 5 years beginning January 1998, for payment of all or some of the Medicare SMI premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The payment of this QI benefit is 100 percent federally funded, up to the State's allocation.

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